84-1406

No.

Office - Supreme Court, U.S.
FILED
MAR 6 1985
ALEXANDER L. STEVAS
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

R. ANTHONY MARRESE, M.D., and BONE AND JOINT SURGEONS, INC.

Petitioners,

v.

INTERQUAL, INC., et al.,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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32 pp

QUESTIONS PRESENTED

1. Does a state's authorization of medical peer review committees, combined with a grant of civil immunity for the good faith determinations and actions of such committees, constitute a clear articulation and affirmative expression of state policy in favor of group boycotts and other anticompetitive conduct sufficient to satisfy the "clear articulation and affirmative expression" requirement for state action immunity from federal antitrust liability?

2. Does a state "actively supervise" the medical peer review procedure as required for the application of state action antitrust immunity when no state agency has the authority to control the actions or affect the decisions of a medical peer review committee?

3. Does the possibility of state court review of the good faith of medical peer review committee proceedings constitute "active state supervision" for purposes of state action antitrust immunity?

4. Does the possibility of a restriction of peer review by the application of the federal antitrust laws bear upon the determination of whether peer review activities constitute state action so as to immunize such activities from those laws?

PARTIES TO THE PROCEEDINGS

R. ANTHONY MARRESE, M.D., and BONE & JOINT SURGEONS, INC., an Indiana corporation,

Petitioners,

v.

INTERQUAL, Inc., a Delaware corporation,

and

DEACONESS HOSPITAL, an Indiana not-for-profit corporation,

and

WILLIAM H. ALLEN, M.D., BRYANT A. BLOSS, M.D., THOMAS EVANS, M.D., AHMET K. PERCIEL, M.D., PEDRO DOMINQUEZ, M.D., SAM B. BAKER, M.D., KENNETH NACHTNEBEL, M.D., DAVID A. JOHNSON and JOHN RENDER,

and

C. LE ROY ANDERSON, DAVID L. BARNING, C. JACKSON BUSCHKILL, MRS. JEAN G. DREMSTEDT, GERALD M. FINNEY, PHILLIP J. GEIER, MELVIN L. KALLENBACH, WILLIAM L. KECK, ROBERT L. KOCH, WILLIAM D. POWELL, DONALD A. RAUSCH, BERNARD E. SCHACKE, DONALD E. STEEDLY, D.W. VAUGHN, and JAMES W. VOGEL,

Respondents.

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Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

Petitioners, R. ANTHONY MARRESE, M.D. ("Dr. Marrese"), and BONE & JOINT SURGEONS, INC., hereby respectfully request that a writ of certiorari issue to review the judgment and decision of the United States Court of Appeals for the Seventh Circuit entered on November 6, 1984, as corrected on November 7, 1984.

OPINION BELOW

The decision of the Court of Appeals is reported at 748 F.2d 373 (1984) and appears as Appendix 1-44 in its corrected form.

JURISDICTION

This appeal is taken from a judgment entered on November 6, 1984, and amended on November 7, 1984, by the United States Court of Appeals for the Seventh Circuit. A timely petition for rehearing with suggestion for rehearing in banc was denied on December 27, 1984.

The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES INVOLVED

Ind. Code §§ 34-4-12.6-1 to 4; Ind. Code § 25-22.5-2-1; Ind. Code § 25-22.5-2-7; Ind. Code § 25-22.5-3-1; Ind. Code § 25-22.5-6-2.1; Ind. Code § 25-22.5-6-3; Ind. Code § 16-10-1-1; Ind. Code § 16-10-1-10; Ind. Code § 16-10-1-2; Ind. Code § 16-10-1-3; Ind. Code § 16-10-1-11; Ind. Code 16-10-1-6.5; Ind. Code § 16-10-1-6.5 (April 1983 amendment) and 410 Ind. Adm. Code 15-1-8(c) are set forth in the Appendix at pp. 127-144.

STATEMENT OF THE CASE

A) PROCEDURAL STATUS

On February 28, 1983, the District Court dismissed petitioners' First Amended Complaint because the facts alleged did not support the proposition that the restraint upon petitioners' practice caused more than an insubstantial effect upon interstate commerce (App. 95-96). On March 18, 1983, that Court denied the petitioners' motion for leave to file a Second Amended Complaint which contained additional jurisdictional allegations (App. 121). A timely appeal was taken from the District Court rulings and the jurisdictional issues were argued before the Seventh Circuit Court of Appeals on March 29, 1984. On August 10, 1984, the Circuit Court, *sua sponte,* ordered briefing on the additional issues of whether the respondents' actions enjoyed immunity from the federal antitrust laws due to the state action exemption doctrine and whether the petitioners' allegations of anticompetitive motivation were relevant and appropriately pleaded (App. 45-46). After briefs were filed, but without an evidentiary hearing in the District Court on the extent and nature, if any, of the State of Indiana's supervision of a private hospital's peer review process, the Seventh Circuit found that, although the petitioners had alleged facts sufficient, at the pleading stage, to establish the jurisdictional requirements of interstate commerce under the Sherman Act (App. 18-20), the respondents' conduct was exempt from the federal antitrust laws under the doctrine of "state action" immunity (App. 42-44). That court, therefore, affirmed the dismissal of this action brought under Sections 1 and 2 of the Sherman Act (App. 1).

B) THE PARTIES

Petitioner, Dr. Marrese, is a 42 year-old board-certified orthopaedic surgeon licensed to practice medicine in the states of Indiana and Illinois, employed by Petitioner, Bone & Joint Surgeons, Inc., an Indiana corporation with offices in Evansville, Indiana. Dr. Marrese graduated *magna cum laude* from Loyola Stritch School of Medicine in Chicago, Illinois, and, at

the same time, received a Masters of Science Degree in Physiology from the Graduate School of Loyola University. He interned at The John Hopkins Hospital in Baltimore, Maryland, and did his residency in orthopaedic surgery at the Northwestern University Hospitals (App. 99). Dr. Marrese has exhibited original scientific materials at numerous meeting of major medical associations from 1969 to 1982, and in November 1983 delivered a paper at Indiana University on the use of thermography in the diagnosis of spinal disc disease. In addition, he is the holder of three original patents on antipollution devices for anesthesia machines currently in use throughout the United States. In 1981, he received the Humanitarian Award of the City of Evansville, the only community from which he practiced medicine until his exclusion from the medical staff of respondent, Deaconess Hospital (the "Hospital").

The Hospital in Evansville, Indiana is a 650-bed institution possessing surgical and diagnostic facilities unique to the "tri-state area" of southern Indiana, western Kentucky and southern Illinois (App. 102, 116). When Dr. Marrese began his medical practice in Evansville in 1973 as an employee and thereafter as a partner of another orthopaedic surgeon on the staff of the Hospital, he was granted full professional medical staff privileges. In 1975, he became a self-employed orthopaedic surgeon employed by his solely owned corporation, Bone and Joint Surgeons, Inc., and continued to hold staff privileges at the Hospital.

C) MEDICAL PEER REVIEW AND THE DEACONESS HOSPITAL PROCEEDINGS

The Indiana Legislature has authorized a hospital's professional staff to establish a committee to evaluate the patient care rendered by members of its staff. Ind. Code §§ 34-4-12.6-1 to 4. It has extended state court immunity from civil liability to the statements or determinations of persons who participate in this peer review process, provided that their statements or

determinations in the course of such proceedings are made "in good faith." Ind. Code 34-4-12.6-3. The Hospital has established a procedure for one internal evidentiary hearing and one so called review proceeding (also internal) after any adverse action against a medical practitioner by the medical executive committee or the board of directors of the Hospital (App. 73, 74).

Dr. Marrese's troubles at the Hospital began shortly after he questioned Hospital staff members about the denial of his application for membership in the American Academy of Orthopaedic Surgeons and expressed his intent to file a state court action which was the predecessor to a case known to this Court as *Marrese, et al. v. American Academy of Orthopaedic Surgeons,* ____ S. Ct. ____, 83-1452 (March 4, 1985) (Justice Burger, concurring in the Judgment). In February 1978, the chairman of the Hospital's medical staff executive committee recommended that an audit be conducted by the Hospital's medical audit committee of all back surgeries performed at the Hospital (App. 109). When it was discovered that Dr. Marrese was a member of the medical audit committee, a special ad hoc committee (the "SAHC") was established to perform the audit.

Although there were approximately three times as many lumbar laminectomies as spinal fusions performed at the Hospital during the audited period, SAHC audited 50 lumbar laminectomies and 40 spinal fusions, knowing full well that Dr. Marrese performed the vast majority of spinal fusions at the Hospital (App. 110). Notwithstanding the fact that only 68 percent of the lumbar laminectomies audited met nationally established criteria, SAHC approved the lumbar laminectomies performed by the Hospital staff. Only 2 of the 50 audited laminectomies were performed by Dr. Marrese, and both of those surgeries met all nationwide and areawide criteria in addition to those adopted by the audit committee. Of the 40 spinal fusions audited by SAHC, 32 were performed by Dr. Marrese and these, too, met all nationwide and areawide professional criteria. Nonetheless, SAHC elected to examine

these operations by the arbitrary and inherently subjective criterion of what it considered to be the "appropriateness"—though not the excellent results—of Dr. Marrese's surgical procedures (App. 110).

Although there had never been any patient complaints about Dr. Marrese's surgeries, SAHC recommended that all of Dr. Marrese's laminectomies and spinal fusions should be monitored and that those of his cases which did not have positive radiological findings should be subjected to a mandatory second opinion. However, final action was never taken by the medical staff executive committee on this SAHC recommendation. SAHC then sent 8 of Dr. Marrese's 32 spinal fusions to an outside auditor, who could draw no conclusions about Dr. Marrese's surgical procedures. Instead, he recommended that *all* spinal procedures performed by orthopaedists and neurosurgeons at the Hospital be submitted to outside audits. The medical staff executive committee likewise declined to act on this recommendation (App. 111).

In August 1981, the medical staff executive committee sought out the service of respondent, InterQual, Inc., of Chicago, Illinois ("InterQual") to audit *only* Dr. Marrese's spinal procedures. InterQual conducted an off-site evaluation of 93 of Dr. Marrese's procedures and in early 1982 submitted its report to the medical staff executive committee. The petitioners have alleged that this report was seriously flawed because it employed no published criteria, misstated the medical records, ignored reports when the record under review referred to additional available reports justifying the surgery, failed to obtain or consider the patient charts or review x-ray pictures, suggested "Fourth Generation C.T. scans" when such procedures were not technically available during the period in question and contained so many clerical and interpretive errors that it reflected a total lack of good faith and conspiratorial malice towards Dr. Marrese (App. 112-113).

In March 1982, more than six months after this secret InterQual audit, Dr. Marrese was first advised that selected spinal surgeries performed by him had been reviewed by that out-of-state company. On April 28, 1982, he was advised that the medical staff executive committee had recommended the revocation of his staff membership and clinical privileges on the basis of the InterQual report (App. 113, 150-151).

Dr. Marrese immediately demanded a hearing pursuant to the Hospital's "Fair Hearing Plan" (App. 73-79). On July 9, 1982, he was advised that a hearing would be held at the Hospital on July 24, 1982. However on July 12, 1982, this lawsuit was filed and the medical staff executive committee cancelled the hearing. The District Court dismissed Dr. Marrese's Amended Complaint on February 28, 1983, and Petitioners' Notice of Appeal was filed on March 25, 1983. On May 18, 1983, Dr. Marrese was advised that his previously cancelled hearing had been rescheduled for July 9th and 10th, 1983. In the same correspondence he was also advised of the composition of the hearing panel, that the Hospital Medical Staff did not intend to introduce *any* evidence on the cases examined by InterQual (even though the InterQual report had formed the basis of the medical staff executive committee's adverse recommendation) but that the committee had instead decided to amend the charges to add new allegations against him (App. 152).

Dr. Marrese objected to the composition of this new hearing panel, all the members of which were appointed by the president of the medical staff, a defendant in this litigation, and the procedural hearing officer, another defendant herein. His objections to the hearing panel were based upon the fact that one of the five panel members was a father of a witness scheduled to testify against him at the hearing and a partner of the same defendant who had appointed the panel; two other members of the panel were also partners of defendants in this litigation, all of whom were scheduled to testify against Dr. Marrese; another member had a strong personal bias against

orthopaedic surgeons performing spinal surgery; and the last member was a family practitioner with no expertise whatsoever in the surgical specialty he was called upon to evaluate (App. 152-153). Because no action was taken by the Hospital in response to these objections, Dr. Marrese filed a suit for preliminary injunction in the Indiana state court on July 7, 1983. On July 8, 1983, that Court held a hearing and entered an order denying Dr. Marrese's request for injunctive relief (App. 152).[1] On that same day, one of the panel members who was a partner of a defendant in this litigation and a witness scheduled to testify, voluntarily withdrew from the hearing panel. The Hospital Medical Staff then recommended the appointment to the hearing panel of another defendant in this litigation. The Circuit Judge, hearing the preliminary injunction case, approved the Hospital's recommendation, but, on the morning of the hearing, off the record, withdrew that approval.

The hearing proceeded for sixteen hours on July 9, 1983, and nine hours on July 10, 1983, with a panel of four, rather than the five members called for in the Hearing Plan (App. 77). A defendant in this litigation continued to serve as the procedural hearing officer. Notwithstanding the testimony of a nationally recognized neurosurgeon, a nationally recognized radiologist and a nationally recognized orthopaedic surgeon that all of Dr. Marrese's surgical procedures were properly performed, and notwithstanding what can only be described as a lack of any credible evidence to the contrary, the hearing panel, on September 14, 1983, recommended that Dr. Marrese's staff membership and clinical privileges at the Hospital be terminated. His clinical privileges were immediately terminated, and on October 23, 1983, the Hospital's board of directors, sitting as an "appellate review" panel, ratified the action of the Hospital's peer review committee and immediately

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[1] A subsequent appeal of that order to the Indiana Court of Appeals was dismissed because the issues raised were considered moot (App. 156-157).

terminated Dr. Marrese's staff membership. Dr. Marrese has not practiced at the Hospital since that date, and in fact, no longer holds any hospital privileges in Evansville, Indiana.

D) THE INDIANA MEDICAL LICENSING BOARD

There were no representatives of the Indiana Medical Licensing Board or any other state agency on the Hospital's peer review committee nor did that Board or any state agency have authority to place a representative on that committee. The recommendation of the committee became effective without any action by the Indiana Medical Licensing Board or any other state agency, and no agency of the State of Indiana had or has any authority to review, affirm or reverse the decision of the Hospital's peer review committee.

The Hospital's board of directors reported to the Indiana Medical Licensing Board, as required, the results and circumstances of the decision to revoke Dr. Marrese's medical staff privileges. Ind. Code § 16-10-1-6.5(b). The Licensing Board, consisting of seven members appointed by the Governor of Indiana (Ind. Code § 25-22.5-2-1), is empowered to revoke a practitioner's license or else to suspend, censure or place a medical practitioner on probation pursuant to Ind. Code § 25-22.5-6-2.1. When the Hospital's governing board advised the Indiana Medical Licensing Board of the action which it had taken against Dr. Marrese, that report was given no greater weight than any other complaint made by any other person against a medical practitioner. Ind. Code § 25-1-7.5(1). The report of the Hospital still awaits a recommendation from the Indiana Attorney General's office as to whether or not it wishes to prosecute Dr. Marrese pursuant to Ind. Code § 25-1-7-7(a).

E) THE HOSPITAL LICENSING COUNCIL

There also exists in the State of Indiana a State Board of Health which, through a Hospital Licensing Council consisting of eight members appointed by the Governor of that state, is

empowered to license and regulate hospitals and ambulatory out-patient surgical centers. That Council has the power to suspend or revoke a hospital's license for conduct or practices found by the Council to be detrimental to the welfare of its patients. Ind. Code § 16-10-1-3-10. If applicants or holders of a hospital or ambulatory care license are aggrieved by the action of the Hospital Licensing Council and the Board of Health, they are authorized by Indiana statute to appeal such decisions to a state court. Ind. Code 16-10-1-11.

While the Hospital Licensing Council is entitled to review the confidential minutes of meetings of a peer review committee, it reviews this information for purposes entirely unrelated to the peer review process. Its review is part of its compilation of information germane to its recommendation to the State Board of Health regarding annual hospital license renewal. The Licensing Council plays no role in the peer review process and has no authority to affect the decision of a peer review committee to revoke a particular doctor's staff membership or clinical privileges.

F) STATE COURT IMMUNITY FOR PEER REVIEW PROCEEDINGS CONDUCTED IN GOOD FAITH

The legislature of the State of Indiana has extended state court immunity to persons involved in peer review proceedings only to the extent that their activities are conducted in good faith. Ind. Code § 34-4-12.6-3. Unlike the Hospital Licensing Act there is no provision in the Peer Review Act limiting appeals to the state courts of Indiana. On the issue of the lack of good faith of the Hospital's peer review committee the petitioners have alleged that Dr. Marrese's exclusion from the medical staff of the Hospital was the result of the following underlying anticompetitive conspiracies, all of which were conducted in the utmost *bad* faith:

> One: Defendants were seeking to exclude Dr. Marrese from the relevant market because of his opposition to their anticompetitive trade practices and because he was a serious competitive threat to the Defendants (App. 106).

Two: Defendants were competitively threatened because of Dr. Marrese's ability to attract more patients than any other physicians at the Hospital and because he refused to abide by certain anticompetitive trade practices that were present there and throughout the relevant market (App. 107).

Three: Defendants' efforts to exclude Dr. Marrese were motivated by his vigorous competitive behavior including his treatment of other doctors' patients without a referral from them and his refusal to share his practice with other orthopaedic surgeons (App. 113).

Four: The Defendants feared Dr. Marrese's competition because he was capable of performing surgical procedures that his local competitors were unable to perform. He was therefore charged with doing "too many" backs (App. 109-113).

REASONS FOR GRANTING THE WRIT

I. THE SEVENTH CIRCUIT'S OPINION ESTABLISHES A NEW AND INAPPROPRIATE TEST FOR STATE ACTION IMMUNITY WHICH SUBSTITUTES WHAT IT CONSIDERS TO BE PERVASIVE REGULATION OF A PROFESSION FOR THE *PARKER* REQUISITE OF STATE COMPULSION OF THE CHALLENGED OF ANTICOMPETITIVE CONDUCT, OR AT THE VERY LEAST, A REASONABLE AND NECESSARY RELATIONSHIP BETWEEN THE CLEARLY ARTICULATED STATE POLICY AND THAT ANTICOMPETITIVE CONDUCT.

The appropriate analysis for anticompetitive action by private parties in determining the applicability of the state action immunity doctrine is presently the subject of considerable debate among the circuits notwithstanding this Court's decision in *Goldfarb v. Virginia State Bar,* 421 U.S. 773 (1975), which announced that "[t]he threshold inquiry in determining if an anticompetitive activity is State action of the type the Sherman Act was not meant to proscribe is whether the activity is required by the State acting as sovereign." *Id.* at 790.

Applying this test, the majority in *United States v. Southern Motor Carriers Rate Conference,* 702 F.2d 532 (5th Cir. 1983), *cert. granted,* 52 U.S.L.W. 3891 (June 11, 1984) (No. 82-1922), held that a private party is immune from federal antitrust liability only if the state *compels* the specific anticompetitive conduct at issue, writing: "So long as the State merely allows, but does not compel, anticompetitive conduct, the decision to adopt such conduct remains that of the individual and is within the scope of the Sherman Act." *Id.* 537. This Court has also found that actions undertaken pursuant to a "clearly articulated and affirmatively expressed state policy to replace competition with regulation" meet this threshold standard. *Hoover v. Ronwin* ____ U.S. ____, 104 S. Ct. 1989, 1995 (1984); *California Retail Liquor Dealers Ass'n. v. Midcal Aluminum, Inc.* 445 U.S. 97, 105 (1980).

On the other hand, the Second Circuit in *Capital Telephone Co. v. New York Telephone Co.*, No. 84-7176 (2d Cir. Dec. 18, 1984), rejected the "compulsion" test in favor of a broader standard which attempts to determine whether the challenged restraint of competition is "reasonably necessary or related to the subject of the legislation." *Id.*, Slip. Op. at 890. The Sixth Circuit has also adopted a similar "relationship" test for evaluating challenges to conduct by public parties: the challenged restraints must be a reasonable and foreseeable exercise of an agency's delegated powers and must be reasonably designed to promote the State's policy within a designated field of regulation. In that event, a presumption arises that the restraints stem from a "clearly and affirmatively expressed State policy to displace competition," through regulation. *Hybud Equipment Corp. v. City of Akron*, 742 F.2d 949, 960-61 (6th Cir. 1984); *see also U.S. v. Title Ins. Ruling Bureau of Ariz., Inc.* 700 F.2d, 1247, 1252-53 (9th Cir. 1983), *cert. denied.*, 52 U.S.L.W. 3891. (June 11, 1984).

These standards have evolved from a line of this Court's decisions beginning with *Parker v. Brown*, 317 U.S. 341 (1943), and most recently continued in *Hoover v. Ronwin*, ____ U.S. ____, 104 S.Ct. 1989 (1984). These cases teach that the ultimate goal of State action immunity is to "preserve the principles of state sovereignty and federalism without disregarding the procompetitive, free enterprise values embodies in the federal antitrust laws." *Marrese v. InterQual*, 748 F.2d 373, 386 (7th Cir. 1984) (App. 26). While there is a continuing dispute about the exact degree of state compulsion that is required in order for private parties' actions to become immune from the federal antitrust laws, the conspicuous fact is that under *any* of these standards the State of Indiana has not "clearly articulated and affirmatively expressed" a state policy to eliminate competition in the manner that it is alleged to have occurred in this case, nor was the conduct of respondents a reasonable and necessary outgrowth of the peer review process.

The Seventh Circuit has apparently failed to recognize that "pervasive regulation" of a profession in general is insufficient evidence of legislative intent to displace competition with private conspiracies in restraint of trade under the guise of legitimate peer review. *National Gerimedical Hospital v. Blue Cross of Kansas City,* 452 U.S. 378, 388-390 (1981); *Otter Trail Power Co. v. United States,* 410 U.S. 366, 372-375 (1973); *Northcrop Corp. v. McDonnell Douglas Corp.,* 705 F.2d 1030, 1056 (9th Cir. 1983) *cert. denied,* 52 U.S.L.W. 3265 (Oct. 3, 1983); *Phonetele, Inc. v. AT&T,* 664 F.2d 716, 729 (9th Cir. 1981), *cert. denied,* 459 U.S. 1144 (1983). *See also* Areeda, *Antitrust Immunity for "State Action" After Lafayette,* 95 Harv. L. Rev. 435, 438 (1981).

In the instant case, the Seventh Circuit has erroneously concluded that the anticompetitive activities at issue are "clearly articulated and affirmatively expressed" as Indiana's state policy. *Marrese v. Interqual, Inc.* (App. 30). But the Seventh Circuit confuses an Indiana policy favoring peer review committees to promote quality medical care with the necessary "clear and affirmative" expression of legislative support for the particular anticompetitive conduct undertaken by the respondents. Thus, the opinion states:

> The State of Indiana has "clearly articulated and affirmatively expressed as state policy" that hospital medical staffs are to form peer review committees and that such committees are to review the quality and necessity of the care provided patients, to evaluate the qualifications of staff members, and review the merits of any recommendation against a staff member. Ind. Code §§ 16-10-1-6.5, 34-4-12.6-1. As a necessary and reasonable consequence of this state mandated medical peer review process, hospital staff members must review the medical treatments, diagnostic procedures, and surgical procedures of competing staff members and, when required, recommend the revocation of staff privileges. Thus, the defendants' conduct, as members of or consultants to the hospital board, the SAHC, and the Medical Staff Executive Council, in reviewing Dr. Marrese's surgical procedures and recommending that his staff privileges be revoked satisfies the first element of the Parker test. (App.30)

This analysis misconstrues the true nature of the so-called *Parker* test, which seeks to ensure that the challenged activity is truly that of the state and therefore entitled to immunity, rather than that of a private association attempting to use its power to restrain competition at the expense of the public interest. *See Hoover v. Ronwin*, ____ U.S. ____, 104 S.Ct. 1989, 2004 (1984) (Stevens, J., dissenting); Areeda, *Antitrust Immunity for "State Action" After Lafayette*, 95 Harv.L.Rev. 435, 437-438 (1981).

Because of the overriding importance of the procompetition policy embodied in the federal antitrust statutes, this Court has consistently required a *very specifically expressed* state policy in favor of the alleged anticompetitive action in order to satisfy this first requirement for *Parker* immunity. Thus, in *California Liquor Dealers v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980), this Court found that the challenged pricing system was clearly the policy of the State of California, "forthrightly stated and clear in its purpose to permit resale price maintenance." 445 U.S. at 105. Similarly, in *New Motor Vehicle Board of California v. Orrin W. Fox Co.*, 439 U.S. 96, 109 (1978), this Court found a "clearly articulated and affirmatively expressed" state policy to "displace unfettered business freedom in the matter of the establishment and relocation of automobile dealerships." Therefore, it found that a comprehensive state-supervised program requiring state approval of the location of automobile dealerships, which necessarily replaced "unfettered business freedom," was immune from Sherman Act liability.

The state policies in *Midcal Aluminum* and *New Motor Vehicle Board* specifically referred to the challenged conduct. By contrast, no such anticompetitive restraints are stated as the policy of the State of Indiana. On the contrary, the state policy in question is the promotion of quality medical care through peer review procedures, and to that end the Indiana legislature has expressly required that such procedures be conducted in "good faith" if they are to enjoy even a state law civil

immunity. This policy cannot reasonably be read as an all-encompassing effort to replace competition with regulation.

If competition were inconsistent with Indiana's state policy, then a far more comprehensive regulatory scheme would have been adopted. Instead, Indiana's legislative policy presumes that competition will continue to exist in the Indiana medical community. Accordingly, competitive forces, not state law, are supposed to regulate the number of licensed physicians practicing in a given specialty, in a given region, or indeed in a given hospital. The State makes no attempt to set minimum or maximum fees; competition determines the fees a physician can charge. Finally, Indiana law does not even authorize, much less, compel, a group boycott against a physician for specifically anticompetitive purposes.

Even if this Court applies the "reasonable relationship" test of *Capital Telephone* and *Hybud, supra,* to the instant case, which involves purely private activity, the activity at issue here is still not immune from antitrust liability. Petitioners have alleged that the respondents engaged in a horizontal group boycott through a concerted refusal to deal (App. 112), that they have attempted to reduce the output of surgical services by the application of arbitrary and restrictive criteria as determined and applied by direct competitors of the petitioners (App. 110), and that they have likewise attempted to coerce conformity to a local "shared equipment system" (App. 108) and a local "prior referral" system (App. 108), all with the intent to monopolize the relevant market (App. 114). Such action is *not* a necessary or reasonable consequence of the legitimate peer review process, which was intended by the Indiana legislature to be conducted in good faith; the medical peer review process as contemplated by the Indiana legislature can be conducted, *and was intended by the legislature to be conducted,* without violating the Sherman Act.

This same element of statutory intent is a critical distinction between *Southern Motor Carriers, supra,* and this case. In

Southern Motor Carrier, the respective States had specifically approved the submission of joint rate schedules to the state regulatory commissions. *United States v. Southern Motor Carrier Rate Commission,* 467 F.Supp. 471, 475-76 (N.D. Ga. 1979). By contrast, in the present case, as demonstrated above, the State of Indiana has *not* authorized the anticompetitive conduct challenged by Dr. Marrese and this conduct was *not* a reasonably necessary result of peer review.

By thus misconstruing the applicable law concerning the "clearly articulated and affirmatively expressed" requirements the Seventh Circuit has in effect removed from antitrust regulation an entire branch of professional anticompetitive conduct solely because of the unquestioned state interest in the delivery of quality medical services. The circuit court's message is clear: the federal antitrust laws and their overriding policy in favor of competition are dead as they relate to medical peer review in the Seventh Circuit. Because of a state's unquestioned interest in quality medical care, all manner of specifically anticompetitive practices within the medical profession are now to be insulated from antitrust scrutiny. Such an approach will have a disastrous impact on price and quality competition in the medical field and can only harm the consumer—the very person whom Indiana's policy seeks to protect.

II. THE SEVENTH CIRCUIT'S FINDING OR *PARKER* IMMUNITY WHEN THE MEDICAL PEER REVIEW PROCESS IS UNSUPERVISED BY ANY STATE AGENCY AND THE STATE'S ROLE IN SUPERVISING THE MEDICAL PROFESSION IS ENTIRELY UNRELATED TO THE PEER REVIEW PROCESS, IGNORES THE PURPOSE OF THE STATE ACTION DOCTRINE, WHICH IS TO IMMUNIZE FROM ANTITRUST LIABILITY ACTIONS WHICH ARE TRULY THOSE OF THE STATE ACTING AS SOVEREIGN.

The supervision requirement for *Parker* immunity reflects a concern with the risks of private abuse of state-created

regulatory schemes. Active state involvement is expected to reduce the temptation for private gain. *See generally* Areeda, *Antitrust Immunity for 'State Action' After Lafayette,* 95 Harv.L.Rev. 435 (1981). Where there is no such supervision, the improper exercise of delegated authority is indistinguishable from any other conduct violative of the antitrust laws. As Justice Stevens observed in *Hoover v. Ronwin:*

> Experience in the administration of the Sherman Act has demonstrated that there is a real risk that private associations that purport merely to regulate professional standards may in fact use their powers to restrain competition which threatens their members.

104 S.Ct. at 2012 (Stevens, J., dissenting).

In the instant case, the Seventh Circuit has erroneously concluded that the respondents' anticompetitive conduct is subject to sufficient "active state supervision" to immunize it from Sherman Act liability. *Marrese v. Interqual* (App. 34-35). This "supervision," as described by the Circuit Court, consists of a possible *de novo* hearing before the Indiana Medical Licensing Board on the issue of the possible revocation of Dr. Marrese's license and before the Hospital Licensing Council on the issue of the possible revocation of the Hospital's license for its alleged failure to review the professional practices in the Hospital for the purposes of reducing morbidity and mortality and improving the care of patients. Ind. Code 16-10-1-6.5. In this regard, the Circuit Court has totally misconstrued the "active state supervision" requirement for *Parker* immunity.

This second requirement is properly viewed as inextricably connected with the first requirement, that the challenged activities must be "compelled" by the state or at least undertaken pursuant to a "clearly articulated and affirmatively expressed state policy to displace competition with regulation." As with the first requirement, the "active state supervision requirement relates to the particular activities in question not, as the Seventh Circuit suggests, to the supposed pervasive regulation of the

entire medical profession. *See Hoover v. Ronwin*, ____ U.S. ____, 104 S.Ct. 1989. (1979), *California Retail Liquor Dealers, Ass'n. v. Midcal Aluminum, Inc.* 445 U.S. 97 (1980); *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389 (1978) (plurality opinion); *Cantor v. Detroit Edison Co.*, 428 U.S. 579, 604) (Burger, C.J., concurring in part). In *Midcal Aluminum*, for example, the challenged resale price maintenance scheme was found to be the specifically stated policy of the State of California. 445 U.S. at 105. Yet the state's failure to establish prices, review the reasonableness of price schedules, regulate the terms of fair trade contracts, monitor market conditions, and reexamine the program all indicated a lack of active state supervision of this policy. *Id.* at 105-106. In contrast, the challenged activity by the petitioner in *Hoover v. Ronwin* (bar admission procedures) was found to be sufficiently supervised by the state to impose antitrust immunity. ____ U.S. ____, 104 S. Ct. 1989. The Court found that the program in question "carefully reserves to the [State Supreme] Court the authority to make the decision to admit or deny [admission to the bar], and that decision is the critical state action here." *Id.* at 2001.

The review of peer review committee decisions or recommendations found to be "supervisory" by the Seventh Circuit is not supervision of that process at all, but instead relates only to the completely independent issue of whether or not a medical practitioner's or hospital's license should be revoked or suspended.

The Medical Licensing Board does not reexamine the peer review proceedings to determine their compliance with or deviation from state policy, nor does it have authority to review, reverse or affirm the decision of a peer review committee. Peer review committee decisions are implemented without the advice of the Medical Licensing Board; that Board's involvement with the peer review process is limited to its examination of committee records and reports for purposes unrelated to "peer review." The same is true of the review by the Indiana State

Board of Health and the Council appointed pursuant to Ind. Code § 16-10-1-3 of a hospital's overall health care practices: such generalized supervision of hospitals for purposes of license renewal simply has nothing to do with the active supervision of particular peer review proceedings.

The Fifth Circuit in *Southern Motor Carriers* did not find it necessary to reach the issue of supervision but even if this Court does examine the supervision question in that case, *Southern Motor Carriers* is factually distinguishable from this case. Under the regulatory schemes of the five states involved in *Southern Motor Carriers,* rate schedules and tariffs submitted to the various state commissioners could not take effect unless and until approved by those bodies. *United States v. Southern Motor Carriers Rate Conf., Inc.,* 467 F.Supp. 471, 476-78 (N.D.Ga. 1979). In the instant case, in complete contrast peer review committee findings and recommendations take effect without approval or even review by any state body.

This Court has decided cases at both ends of the "supervision" spectrum. In *Midcal Aluminum,* the facts presented indicated a complete lack of supervision over a resale price maintenance scheme. 445 U.S. at 105-106. *Hoover v. Ronwin,* on the other hand, presented a situation in which the challenged activity was, in essence, undertaken by the State through its Supreme Court. ____ U.S. ____, 104 S.Ct. at 2001. This case presents a unique opportunity to define the requisite degree of state supervision in the state action immunity area. There is nothing in the policy or legal precedent surrounding the state action doctrine to suggest that a state agency which conducts a *de novo* hearing on an issue not considered by the peer review committee, i.e., the medical practitioner's right to hold a state medical license, but *without the ability to affect the ultimate actions of the committee,* constitutes "active supervision" of the peer review process. The Seventh Circuit's decision in this case leaves the consumer without either the

benefits of competition or the protection of state regulation. Permitting respondents to cast the "gauzy cloak" of state action over their purely voluntary, unsupervised conduct fulfills neither the goals of *Parker* state action immunity, the mandate of the Sherman Act, nor the regulatory policy of the State of Indiana to provide the best available medical care to its residents.

III. THE SEVENTH CIRCUIT'S SUGGESTION THAT THE POSSIBLE REVIEW OF THE GOOD FAITH OF PEER REVIEW PROCEEDINGS BY STATE COURTS CONSTITUTES "ACTIVE STATE SUPERVISION" IS UNPRECEDENTED AND CONTRARY TO FEDERAL ANTITRUST POLICY. IT SUBSTITUTES A NEW RULE OF FEDERAL ABSENTION FOR THE ACTIVE STATE REGULATION THAT IS ESSENTIAL FOR STATE ACTION IMMUNITY FROM THE ANTITRUST LAW.

After inaccurately characterizing the function of the Indiana Medical Licensing Board and the Hospital Licensing Council as "active supervision" of the peer review process, the Seventh Circuit has further declared that the availability of a state court review of the requisite good faith of peer review proceedings comprises "an essential element of State mandated and supervised peer review process in the State." *Marrese v. InterQual* (App. 38) The Circuit Court does not explain this unheard-of interpretation in any detail, but implies that the ultimate resolution of peer review disputes—in essence, the only supervision of the process—rests with the Indiana state court system (App. 38-39). However, in construing the *Parker* doctrine, this Court has never equated judicial review of administrative proceedings, designed to protect due process rights guaranteed by the Fourteenth Amendment, with "active state supervision" of anticompetitive conduct.

The Indiana courts, pursuant to state law, review only the "good faith" of medical peer review committee members. Ind.

Code § 34-4-12.6-3. It is difficult to conceive of a more judicial and less legislative or administrative act. Yet, the Seventh Circuit suggests that this "review" immunizes respondents' anticompetitive acts from antitrust liability. This is an utterly unprecedented distortion of the "active supervision" requirement. The Indiana courts' role in the peer review process is purely judicial in nature. In fact, a court is constitutionally incapable of either implementing or supervising a state policy in favor of quality medical care through peer review, but is limited to an adjudication of the case or controversy placed before it by the parties.

Such an analysis of "active state supervision" to include judicial review by a state court of the "good faith" of a medical peer review panel, is more closely analagous to a new doctrine of federal judicial abstention than it is to a new test for the application of the state action immunity doctrine. Until this decision it had been assumed that federal courts did not dismiss lawsuits simply because state courts *might* entertain an action on the same facts. *Alabama Public Service Commission v. Southern Railroad Co.*, 341 U.S. 341, 361 (1951) (Justice Frankfurter, concurring in the result). This Court, in *Colorado River Water Conservation District v. United States*, 424 U.S. 800, 814-816 (1976), very carefully drafted boundaries for the application of the judicial abstention doctrine, and this case clearly does not fall within any of the categories there established for the application of that doctrine.

Whether this case is viewed as setting forth a novel test for the application of the state action immunity doctrine or a novel approach to the application of the doctrine of federal abstention, the standard suggested by the Seventh Circuit leads to the improbable result of federal antitrust immunity for admittedly anticompetitive conduct. Permitting judicial review thus to replace "active supervision" of anticompetitive activity would serve only to facilitate violations of the federal antitrust laws by masking them with a limited state judicial finding of "good

faith." Such a finding does not and cannot constitute the necessary regulation or supervision of the peer review process by a State.

IV. THE POTENTIAL CONSTRAINTS ON MEDICAL PEER REVIEW RESULTING FROM APPLICATION OF THE FEDERAL ANTITRUST LAWS ARE AN INAPPROPRIATE FACTOR IN DETERMINING WHETHER STATE ACTION IMMUNITY EXISTS.

The Seventh Circuit's analysis of the state action immunity doctrine departs drastically from precedent in its assumption that a state policy generally favoring medical peer review may restrict federal antitrust policy whenever those policies conflict. *Marrese v. InterQual* (App. 42). The Circuit Court opines that "peer review is essential to the very life-blood and heartbeat of medical competency and quality medical care in the State of Indiana and throughout the nation." *Id.* at 37. The Court continues, "[A]n attack upon this state mandated and supervised peer review process, through the federal antitrust laws will compel able and qualified physicians to abdicate their participation in the review of hospital staff members." *Id.* at 42.

Whether or not this is true, the decision to elevate a state policy to the status of national policy restricting the scope of the Sherman Act is not one for any court to make. Rather, under the *Parker* doctrine, this Court has found that the all-important federal economic policy in favor of free competition was never intended to apply to the actions of the States acting as sovereigns. The confusion of the Seventh Circuit on this last point is obvious, for no state policy, however strong, can possibly displace the Sherman Act. *Parker v. Brown*, 317 U.S. 341, 351 (1943); *Cantor v. Detroit Edison Co.*, 428 U.S. 579, 602 (1975). Only "state action" can do so, pursuant to a clearly expressed state policy to replace competition, which is vigorously enforced, through a system of ongoing regulation, and there is no such system of regulation for peer review in the State of Indiana.

The Seventh Circuit's rationale in this case decimates the delicate balance struck by this Court in the area of state action immunity. It provides a virtual carte blanche for professions involved in what the courts may deem to be "important" areas of state policy to engage freely in anticompetitive conduct proscribed by the federal antitrust laws. Congress, in the Sherman Act, enunciated a national policy favoring competition as the means of protecting the welfare of consumers. It is not the role of the Seventh Circuit, nor of any other court, to decide that consumers may be better protected through other means. *United States v. Topco Associates, Inc.*, 405 U.S. 596, 610 (1971).

CONCLUSION

Because there does not exist, in the State of Indiana, a "clearly articulated and affirmatively expressed" statutory policy to displace competition with regulation in the delivery of medical services to consumers, because the legislative authorized medical peer review process could have been successfully carried out and was intended to be carried out without a violation of the federal antitrust laws, and because the only possible "supervision" of the peer review process in this case consists of a possible state court judicial review, Petitioners respectfully pray that this unprecedented and fundamentally unsound decision of the Seventh Circuit be reviewed by this Court.

Respectfully submitted,

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Office - Supreme Court, U.S.
FILED
MAR 6 1985
ALEXANDER L. STEVAS,
CLERK

SUPREME COURT, U.S.
WASHINGTON, D.C. 20543

84-1406

No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

R. ANTHONY MARRESE M.D. and BONE AND JOINT SURGEONS, INC.

Petitioners,

v.

INTERQUAL INC. et al.,

Respondent.

APPENDIX TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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In the

United States Court of Appeals

For the Seventh Circuit

No. 83-1581

R. ANTHONY MARRESE, M.D., and
BONE & JOINT SURGEONS, INC.,

Plaintiffs-Appellants,

v.

INTERQUAL, INC., et al.,

Defendants-Appellees.

Appeal from the United States District Court for the
Northern District of Illinois, Eastern Division.
No. 82 C 4296—George N. Leighton, *Judge.*

ARGUED MARCH 29, 1984—DECIDED NOVEMBER 6, 1984

Before BAUER, COFFEY, *Circuit Judges,* and FAIRCHILD, *Senior Circuit Judge.*

COFFEY, *Circuit Judge.* Plaintiffs-Appellants, R. Anthony Marrese, M.D., and Bone & Joint Surgeons, Inc., appeal the judgment of the United States District Court for the Northern District of Illinois dismissing the plaintiffs' claims under of the Sherman Act §§ 1, 2, 15 U.S.C. §§ 1, 2, for lack of subject matter jurisdiction. We conclude that the defendants' conduct in reviewing Dr. Marrese's surgical procedures and recommending that his clinical privileges at Deaconess Hospital, in Evansville, Indiana, be revoked, is exempt from the Federal antitrust laws under the doctrine of "state action," and thus we affirm the dismissal of the plaintiffs' claims under the Sherman Act §§ 1, 2.

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I

The record reveals that Dr. R. Anthony Marrese, is a Board certified orthopedic surgeon who specializes in the treatment of spinal disorders. Dr. Marrese is the sole shareholder of Bone & Joint Surgeons, Inc., an Indiana corporation with its principal office in Evansville, Indiana. He is licensed to practice medicine in the states of Illinois and Indiana and, at the commencement of this lawsuit, had clinical privileges to practice at Deaconess Hospital, a non-profit corporation located in Evansville, Indiana.[1]

In February 1978, a Special Ad Hoc Committee ("SAHC") comprised of selected members of the medical staff at Deaconess Hospital conducted an audit of the surgical "back" procedures performed at Deaconess.[2] The results of that audit raised questions concerning the "appropriateness of the surgeries performed by Dr. Marrese." Accordingly, the SAHC recommended to the medical staff at Deaconess that all of Dr. Marrese's lumbar laminectomy and spinal fusion cases be monitored, and that any case without a positive radiological finding be subjected to a mandatory second opinion. In August 1980, the SAHC retained Interqual, Inc., an independent, non-affiliated company engaged in the business of performing medical audits, to conduct a further audit of Dr. Marrese's lumbar and cervical surgical procedures. Based upon the findings of the Interqual audit, the SAHC recommended

[1] At oral argument the plaintiffs' counsel informed this court that Dr. Marrese "is no longer practicing in Evansville," but counsel failed to provide this court with any information concerning Dr. Marrese's status at Deaconess Hospital, much less his underlying reason for no longer practicing in Evansville, Indiana. It is clear from the plaintiffs' first amended complaint that Dr. Marrese's clinical privileges at Deaconess had not been revoked prior to the filing of this lawsuit in July 1982.

[2] According to the plaintiffs' first amended complaint, the "back" procedures audited by the SAHC included, *inter alia*, fifty lumbar laminectomies and forty spinal fusions performed by orthopedic surgeons on the staff at Deaconess Hospital.

to the Medical Staff Executive Council at Deaconess that Dr. Marrese's clinical privileges be revoked. On April 28, 1982, the Medical Staff Executive Council adopted the recommendation of the SAHC but stayed implementation of Dr. Marrese's clinical privilege revocation, pending a hearing as required by the hospital's Fair Hearing Plan.

The Fair Hearing Plan at Deaconess was adopted by the medical staff in June 1979 "to provide every practitioner with one evidentiary hearing and with one appellate hearing in the event that any action is taken [including revocation of clinical privileges] by the Medical Staff Executive Council . . . or the Board of Directors of the Hospital." The medical staff's authority to review professional practices within its hospital is provided for in the State of Indiana statutory code:

> "The governing board of the hospital shall be the supreme authority in the hospital
>
> * * *
>
> The medical staff of a hospital shall be an organized group which shall be responsible to the governing board . . . and shall have the responsibility of reviewing the professional practices in the hospital for the purpose of reducing morbidity and mortality, and for the improvement of the care of patients in the hospital. *This review shall include, but shall not be limited to, the quality and necessity of the care provided patients . . . .*"

Ind. Code § 16-10-1-6.5 (1982) (emphasis added). The Indiana statutory scheme for quality control of the medical profession further provides that the personnel of:

> "a committee having the responsibility of evaluation of qualifications of professional health care providers, or of patient care rendered by professional health care providers, or of the merits of a complaint against a professional health care provider that includes a determination or recommendation concerning the complaint

* * *

> shall be immune from any civil action arising from any determination made in good faith in regard to evaluation of patient care . . . ."[3]

Ind. Code §§ 34-4-12.6-1(c), 34-4-12.6-3(c) (1982).[4] The procedure to be followed in reviewing professional practices within a hospital is set forth in Ind. Code § 34-4-12.6-2(b):

> "Any professional health care provider under investigation shall be permitted at any time to see any records accumulated by a peer review committee pertaining to his personal practice and shall be offered the opportunity to appear before the peer review committee with adequate representation to hear all charges and findings concerning his practice and to offer rebuttal information, which shall be a part of the record before any disclosure of the charges and findings hereunder."

The Fair Hearing Plan adopted by the medical staff at Deaconess affords any practitioner adversely affected by a recommendation or action of the Medical Staff Executive

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[3] The Indiana legislature defines good faith as "an act taken without malice after a reasonable effort to obtain the facts of the matter and in the reasonable belief that the action taken is warranted by the facts known." Ind. Code § 34-4-12.6-1(f) (1982).

[4] Effective April 1983, the Indiana legislature amended Ind. Code § 16-10-1-6.5 to provide in pertinent part:

> "The governing board and its employees, agents, consultants, and attorneys have absolute immunity from civil liability for communications, discussions, actions taken, and reports made concerning disciplinary action or investigation taken or contemplated, if such reports or actions are made in good faith and without malice."

Ind. Code Ann. § 16-10-1-6.5(b) (Burns Supp. 1983).

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Council or the Board of Directors, the right to an evidentiary hearing.[5] The hearing is conducted before an evidentiary hearing committee, comprised of five members of the senior or active medical staff.[6] The practitioner may request to be represented by an attorney and/or may be accompanied by a member of the medical staff, and shall also be allowed to:

"(a) call and examine witnesses

(b) introduce exhibits

(c) cross-examine any witness on any matter relevant to the issues

(d) question the qualifications of any witness

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[5] According to the Fair Hearing Plan at Deaconess, a practitioner is entitled to an evidentiary hearing for the following recommendations or actions:

"(a) Denial of initial staff appointment
(b) Denial of reappointment
(c) Suspension of staff membership
(d) Revocation of staff membership
(e) Denial of requested advancement in staff category
(f) A change in staff category not acceptable to the practitioner
(g) Limitation of the right to admit patients
(h) Denial of requested department/service/section affiliation
(i) Denial of requested clinical privileges
(j) Reduction of clinical privileges
(k) Suspension of clinical privileges
(l) Revocation of clinical privileges
(m) Terms of probation
(n) Individual requirement of consultation

[6] The five hearing committee members are appointed by the president of the medical staff when the hearing is occasioned by an adverse recommendation of the Medical Staff Executive Council. On the other hand, when the hearing is occasioned by an adverse recommendation of the governing hospital board, the board president appoints the five members of the hearing committee.

(e) rebut any evidence

(f) request that the record of the hearing be made by use of a court reporter or an electronic recording unit."

At a hearing to review the revocation of a practitioner's clinical privileges, "the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence" in support of its recommendation. According to the Fair Hearing Plan at Deaconess, the burden then shifts to the practitioner to show "by a preponderance of the evidence that the grounds [for revocation] lack any substantial basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious." Following this hearing, the committee compiles its findings and submits them along with a recommendation to either the Medical Staff Executive Council or the Board of Directors, depending upon which body initiated the adverse recommendation or action. After reviewing the committee's findings and recommendation, the council or hospital board affirms, modifies, or reverses the recommendation. If the decision is adverse to the practitioner, he has a right of review before the joint conference committee of the hospital. The Fair Hearing Plan at Deaconess provides that "[t]he practitioner seeking the review may submit a written statement detailing the findings of fact, conclusions and procedural matters with which he disagrees, and his reasons for disagreement." Following submission of the practitioner's statement, the joint conference committee conducts a review hearing and based upon its findings, recommends to the hospital board that the adverse decision be affirmed, modified, or reversed. The board issues a final written decision and if the practitioner's hospital staff privileges are, in fact, revoked, he is entitled to appeal that decision through the Indiana state court system and challenge the "good faith" of the hospital staff members in reaching their conclusion. *See, e.g., Kiracofe v. Reid Memorial Hosp.*, ____ Ind. App. ____, 461 N.E.2d 1134, 1139-41 (1984); *Yarnell v. Sisters of St.*

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Francis Hlth. Serv., ____ Ind. App. ____, 446 N.E.2d 359, 361-63 (1983).[7]

In July 1982, before the Board of Directors at Deaconess had issued their final decision revoking Dr. Marrese's clinical privileges, the plaintiffs (Dr. Marrese and his solely owned company, Bone & Joint Surgeons, Inc.) filed suit in the United States District Court for the Northern District of Illinois against Interqual, Inc., Deaconess Hospital and its Board of Directors in their individual capacity, and members of the SAHC and Executive Committee at Deaconess, including seven doctors, one hospital administrator, and one attorney.[8] The suit alleged that the defendants had conspired to restrain trade in violation of the Sherman Act § 1, had monopolized the market for orthopedic and neurological spinal surgical procedures in Evansville, Indiana in violation of the Sherman Act § 2, and had violated 42 U.S.C. § 1983 by adopting an anticompetitive, unfair, and unconstitutional Fair Hearing Plan under color of the Indiana medical peer review statute, Ind. Code § 34-4-12.6-1 *et seq.*[9] According to the plaintiffs' first amended complaint, "[b]eginning in early 1978 and continuing thereafter to the present, the Defendants have engaged in an unlawful conspiracy to exclude DR. MARRESE from the Evansville, Indiana marketing area by falsely charging that he is unqualified to practice and compete therein." The complaint alleged that the defendants "formulat[ed] and effectuat[ed]" this conspiracy through their actions as members of or consultants to the hospital board, the SAHC, and the

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[7] We express no view concerning the defendants' "good faith" and/or "bad faith" in the present case, as that issue is not presently before the court.

[8] The record reveals that the plaintiffs filed their initial complaint in this action on July 12, 1982. Some two weeks later, on July 27, 1982, the plaintiffs filed their first amended complaint.

[9] The plaintiffs' first amended complaint also included a pendent state claim, alleging that the defendants' actions constituted a tortious interference with business relations.

Medical Staff Executive Council at Deaconess. The plaintiffs sought money damages for the alleged Federal antitrust violations and, pursuant to the Clayton Act § 16, 15 U.S.C. § 26, a permanent injunction restraining defendants from continuing to engage in Federal antitrust violations. In addition, the plaintiffs requested a permanent injunction "enjoining the President of the Medical Staff . . . from naming a committee to sit in review of the recommendation of the Executive Committee of the Medical Staff."

For purposes of establishing the district court's subject matter jurisdiction over the alleged violations of the Sherman Act §§ 1, 2, the plaintiffs claimed that the defendants' activities had a substantial and adverse effect upon interstate commerce. In support of this position, the plaintiffs alleged that:

> "Approximately 45% of the patients treated by DR. MARRESE travel from Western Kentucky and Southern Illinois into the State of Indiana and the vast majority of these patients are treated by DR. MARRESE at DEACONESS HOSPITAL. . . . In addition, DR. MARRESE is a team surgeon for an Illinois high school, and in this capacity has occasion to travel into the State of Illinois, treat injured athletes and when necessary brings them back to the DEACONESS HOSPITAL for the purpose of providing medical treatment for them. In the regular course of his treatment of both his interstate and in-state patients, Plaintiff, DR. MARRESE, through Plaintiff's Bone and Joint Surgeons, Inc. purchases medicine, equipment and related supplies from out-of-state purveyors, derives revenues from the Federal Health Care Program commonly known as Medicare and Medicaid as well as from private out-of-state insurance companies and pays management and accounting fees to various out-of-state consultants. The total amount of said out-of-state purchases, revenues, and fees exceed the sum of $500,000.00 [annually]."
>
> * * *

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> If Defendants' conspiracy is successful in its ultimate objective of driving DR. MARRESE from the Evansville, Indiana marketing area, he will . . . be unable to practice orthopedic medicine anywhere in the continental United States because of the cost of medical malpractice insurance, and because no other hospital could afford the risk of accepting DR. MARRESE on its staff."[10]

The plaintiffs further alleged that:

> "Approximately 25% of the HOSPITAL'S patients travel from Kentucky and Illinois to the HOSPITAL for the purpose of receiving medical and surgical care from its professional staff.
>
> The HOSPITAL'S regular billings with respect to said out-of-state patients are not less than TEN MILLION DOLLARS ($10,000,000.00) per year.
>
> The HOSPITAL also purchases medical supplies and equipment in an amount not less than FIVE MILLION DOLLARS ($5,000,000.00) per year from various out-of-state sources."

In February 1983, the district court dismissed the plaintiffs' first amended complaint in its entirety. The court found that:

> "With respect to interstate commerce, plaintiffs have alleged that Dr. Marrese treats people who travel in interstate commerce; that they purchase medicine and related supplies from out-of-state; that Dr. Marrese travels in interstate commerce as part of his business; and that they receive revenues from out-of-state sources such as insurance companies and Medicare."

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[10] The record before this court reveals that the plaintiffs' allegation of out-of-state purchases, revenues, and fees in excess of $500,000 refers to an annual sum.

Based upon these findings, the court ruled, *inter alia*, that:

> "Plaintiffs have not alleged what effect the defendants attempts to revoke Dr. Marrese's clinical privileges have had on the aspects of interstate commerce alleged. Other than generalized, conclusory allegations plaintiffs have failed to allege any substantial effect on interstate commerce.... Thus, because the court concludes that defendants' allegedly unlawful actions do not have a substantial effect on interstate commerce, [the plaintiffs' claims under the Sherman Act §§ 1, 2] must be dismissed for lack of subject matter jurisdiction."[11]

In March 1983, the plaintiffs filed a motion for reconsideration of the district court's order dismissing the first amended complaint and also filed a motion for leave to file a second amended complaint. The court denied both motions ruling that, "[m]any of the allegations in the Second Amended Complaint are identical to paragraphs in the First Amended Complaint. To the extent that there are differences between the two complaints, they are differences merely of degree not of substance."[12] On ap-

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[11] The court ruled that the plaintiffs' claim of an anticompetitive, unfair, and unconstitutional Fair Hearing Plan at Deaconess Hospital failed to allege sufficient "state action" to state a claim under 42 U.S.C. § 1983. The court further ruled that because the federal claims were dismissed, it no longer retained jurisdiction over the pendent state law claim. The plaintiffs do not appeal these decisions.

[12] The district court denied the plaintiffs' motion for leave to file a second amended complaint and thus that complaint was never made a part of the district court record. It is clear, however, that the judge received and reviewed a copy of the second amended complaint as did the defendants who filed a memorandum in opposition to the plaintiffs' motion for leave to file an amended complaint. On appeal, the plaintiffs have presented this court with a copy of the second amended complaint which alleges, in addition to the allegations of the first

(Footnote continued on following page)

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peal, the plaintiffs contend that the district court erred in dismissing the plaintiffs claims under the Sherman Act §§ 1, 2, for failure to allege a substantial and adverse effect upon interstate commerce.

II

The Sherman Act prohibits "[e]very contract, combination . . . or conspiracy, in restraint of trade or com-

[12] *continued*

amended complaint, that:

> "Approximately 300 patients per year travel from Western Kentucky and Southern Illinois into the State of Indiana for treatment by DR. MARRESE. Each patient is seen by DR. MARRESE on six separate occasions for a total of approximately 1,800 visits per year by out-of-state patients into the State of Indiana from DR. MARRESE. These patients are billed approximately $1,000,000.00 per year by DR. MARRESE and approximately $10,000,000.00 by the HOSPITAL. . . . The vast majority of these patients are treated by DR. MARRESE at least once at the HOSPITAL and a large percentage of these cases involve complex spinal surgery. If DR. MARRESE's privileges at the HOSPITAL are terminated, these patients will not cross state lines into the State of Indiana for their medical treatment for they come to DR. MARRESE because of his superior expertise in spinal diagnosis and treatment."

The second amended complaint also alleges that Dr. Marrese had contracted to purchase a $500,000 computerized tomography body scanner from a New Jersey firm. Specifically, Dr. Marrese alleges that he had made a down payment on the machine, had arranged financing with a Missouri firm, and had entered into an agreement with an out-of-state physician, a "national expert in the field of computerized tomagraphy scanning," to read and interpret the specialized x-rays. Dr. Marrese claims that as a result of the defendants' alleged illegal conduct, he was forced to cancel the agreement to purchase the scanner, the financing arrangement, and the x-ray reading agreement with the out-of-state physician.

merce among the several States," 15 U.S.C. § 1 (1982), and also prohibits "monopoliz[ing] any part of the trade or commerce among the several States." 15 U.S.C. § 2 (1982). It is axiomatic that in pleading a cause of action under the Sherman Act §§ 1, 2, the plaintiff must adequately allege the jurisdictional requirement of interstate commerce. *See McLain v. Real Estate Bd. of New Orleans*, 444 U.S. 232, 241-42 (1980) ("*McClain*"); *Hospital Building Co. v. Rex Hospital Trustees*, 425 U.S. 738, 743 (1976) ("*Hospital Building Co.*"). Thus, the plaintiff's complaint must allege sufficient facts to establish that the defendant's alleged illegal conduct is "in interstate commerce" or has a "substantial and adverse effect" upon interstate commerce. *McLain*, 444 U.S. at 241-42; *Hospital Building Co.*, 425 U.S. at 743. One of the two threshold issues before this court is whether the plaintiffs in the instant case have alleged facts sufficient at the pleading stage of the proceeding to satisfy the jurisdictional requirement of interstate commerce under the Sherman Act.[13]

We note at the outset that "[i]n reviewing the dismissal of a complaint, 'the . . . factual allegations of the complaint are taken as true.'" *Mid-America Reg. Bar. v. Will Cty. Carpenters*, 675 F.2d 881, 883 (7th Cir.), *cert. denied*, 459 U.S. 860 (1982) (quoting *Ashbrook v. Hoffman*, 617 F.2d 474, 475 (7th Cir. 1980)). According to the plaintiffs' first amended complaint, approximately forty-

[13] The record reveals that at the pleading stage of this proceeding the defendants filed a motion to dismiss the plaintiffs' complaint under Fed. R. Civ. P. 12(b)(6) for failure to state a claim upon which relief could be granted. For purposes of the Sherman Act claims, the district court treated the defendants' motion as a motion to dismiss for lack of subject matter jurisdiction under Fed. R. Civ. P. 12(b)(1), and dismissed the claims. According to the Supreme Court in *Hospital Building Co.*, the jurisdictional requirement of interstate commerce may be analyzed under Fed. R. Civ. P. 12(b)(1) or 12(b)(6), "the critical inquiry is into the adequacy of the nexus between [defendants'] conduct and interstate commerce that is alleged in the complaint." 425 U.S. at 742 n.1.

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five percent of Dr. Marrese's patients travel from Illinois and Kentucky into Indiana for treatment.[14] The complaint alleges that the vast majority of these patients are treated at Deaconess Hospital in Evansville, Indiana. In addition, Dr. Marrese claims that he travels into Illinois to treat injured athletes, and when necessary, brings them to Deaconess Hospital for medical treatment. Dr. Marrese further claims that he purchases medicine, equipment, and related supplies from out-of-state purveyors, derives revenues from Medicare, Medicaid, and private out-of-state insurance companies, and pays management and accounting fees to out-of-state consultants. These out-of-state purchases, revenues, and fees allegedly exceed $500,000 annually. Moreover, according to the plaintiffs' first amended complaint, approximately twenty-five percent of the patients receiving medical and surgical care at Deaconess Hospital travel from Illinois and Kentucky, accounting for $10,000,000 in annual hospital billings. The complaint alleges that the hospital purchases approximately $5,000,000 in medical supplies and equipment annually, from out-of-state sources. Finally, Dr. Marrese claims that upon revocation of his clinical privileges at Deaconess, he will no longer be able to practice orthopedic medicine in Evansville, Indiana or anywhere in the United States because no hospital will be able to afford the risk of granting Dr. Marrese staff privileges. It is the plaintiffs' position that these allegations are sufficient, at the pleading stage of the proceeding, to establish a "substantial and adverse effect" upon interstate commerce, and thus satisfy the jurisdictional requirement of interstate commerce under the Sherman Act.

In *Williams v. St. Joseph Hospital*, 629 F.2d 448 (7th Cir. 1980), this court set forth the general rule that "medical practice *per se* and without more is a local activity. To bring it within reach of the [Federal] antitrust laws a substantial and adverse effect upon inter-

[14] Due to the fact that the plaintiffs' second amended complaint was never made a part of the district court record, this court limits its review to the plaintiffs' first amended complaint.

state commerce is requisite." 629 F.2d at 454 (citing *Polhemus v. American Medical Assn.*, 145 F.2d 357, 359 (10th Cir. 1944)). "As long as the restraint in question 'substantially and adversely affects interstate commerce,' the interstate commerce nexus required for Sherman Act coverage is established." *Hospital Building Co.*, 425 U.S. at 743 (citations omitted). According to the Supreme Court in *McLain*, the defendant's activities must "be shown 'as a matter of practical economics' to have a not insubstantial effect on the interstate commerce involved." 444 U.S. at 246 (citing *Hospital Building Co.*, 425 U.S. at 745). Though each case involves a unique set of facts, "[i]f it is interstate commerce that feels the pinch, it does not matter how local the operation which applies the squeeze." *Hospital Building Co.*, 425 U.S. at 743 (quoting *Gulf Oil Corp. v. Copp Paving Co.*, 419 U.S. 186, 195 (1974)); *Williams v. St. Joseph Hospital*, 629 F.2d at 453 n.11; *Tiger Trash v. Browning-Ferris Industries, Inc.*, 560 F.2d 818, 825-26 (7th Cir. 1977), *cert. denied*, 434 U.S. 1034 (1978) (quoting *United States v. Women's Sportswear Assn.*, 336 U.S. 460, 464 (1949)).

In *Hospital Building Co.*, the Supreme Court stated that "[a]n effect can be 'substantial' under the Sherman Act even if its impact on interstate commerce falls far short of causing enterprises to fold or affecting market price." 425 U.S. at 745. According to the Court, if the allegations of the plaintiff's complaint "fairly claim that the alleged conspiracy, to the extent it is successful, will place 'unreasonable burdens on the free and uninterrupted flow' of interstate commerce," that is sufficient, at the pleading stage of a proceeding, to establish a substantial effect upon interstate commerce under the Sherman Act. *Id.* at 746. This court has added that under the "substantial effect" test, "it is unnecessary for an antitrust plaintiff to allege the defendant 'had the purposeful goal of affecting interstate commerce' . . . or that 'the conspiracy threaten[s] the demise of out-of-state businesses or that the conspiracy affect[s] market prices.'" *Tiger Trash v. Browning-Ferris Industries, Inc.*, 560 F.2d

at 826 (brackets original) (quoting *Hospital Building Co.*, 425 U.S. at 745, 746) ("*Tiger Trash*").

Indeed, in *Tiger Trash*, the plaintiff alleged that the defendant, Browning-Ferris Industries ("BFI"), was attempting to monopolize the solid waste collection service of Evansville, Indiana and Henderson, Kentucky, in violation of the Sherman Act § 2. According to the undisputed facts, BFI was an Indiana corporation with twenty customer accounts in Henderson, Kentucky, comprising approximately five percent of BFI's total accounts. The Kentucky accounts produced annual revenues of $30,000 amounting to approximately three to four percent of the annual revenues produced by BFI's Evansville, Indiana accounts. In addition, BFI maintained $6,000 worth of equipment in Kentucky on a permanent basis and used another $100,000 worth of equipment within the state. On the issue of whether or not these facts were sufficient to satisfy the test of "substantial and adverse effect" upon interstate commerce, at the pleading stage of the proceeding, this court ruled that:

> "Plaintiff Tiger Trash may be able to prove that defendants' monopolization caused an effect on interstate commerce 'that is more than merely inconsequential.' *Woods Exploration & Producing Co. v. Aluminum Co. of America*, 438 F.2d 1286, 1303 (5th Cir. 1971), *cert. denied*, 404 U.S. 1047 (1972). Since the relation of the alleged restraints to interstate commerce and their effect upon it are not 'clearly nonexistent' summary judgment for BFI Indiana was inappropriate.
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> * * *
>
> What the proofs will show is another matter, but at least plaintiff must be permitted to show (if it can) that an interstate market, the Henderson-Evansville area, was being monopolized by defendants. *Hospital Building, supra*, 425 U.S. at 747 n.5"

Id. at 826. Similarly, the Supreme Court has stated that at the pleading stage of a proceeding:

> "[A] complaint should not be dismissed unless 'it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief.' *Conley v. Gibson*, 355 U.S. 41, 45-46 (1957); see 5 C. Wright & A. Miller, Federal Practice and Procedure §§ 1202, 1205-1207, 1215-1224, 1228 (1969). This rule applies with no less force to a Sherman Act claim, where one of the requisites of a cause of action is the existence of a demonstrable nexus between the defendants' activity and interstate commerce."

McLain, 444 U.S. at 246. *See also Bunker Ramo Corp. v. United Business Forms, Inc.*, 713 F.2d 1272, 1282 (7th Cir. 1983); *Williams v. St. Joseph Hospital*, 629 F.2d at 453-54.

Since the decisions in *Hospital Building Co.* and *McLain*, the Federal courts have embarked upon a new and vastly expanded interpretation of the interstate commerce requirement under the Sherman Act. As a result, the courts have been deluged with complaints alleging that a hospital's denial or revocation of a doctor's staff privileges constitutes a restraint of trade and/or an attempt to monopolize trade in violation of the Sherman Act §§ 1, 2. *See Pontius v. Children's Hospital*, 552 F. Supp. 1352, 1362-63 (W.D. Pa. 1982); Kissam, Webber, Bigus & Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 Cal. L. Rev. 595 (1982). A common element in these hospital staff denial or revocation cases is a threshold determination by the court of whether or not the doctor's complaint alleges facts sufficient to satisfy the jurisdictional requirement of interstate commerce under the Sherman Act. For example, in *Cardio-Medical Assoc. v. Crozer-Chester Med. Ctr.*, 721 F.2d 68 (3rd Cir. 1983) ("*Cardio-Medical*"), four cardiologists claimed that their denial of specialized staff privileges, preventing them from using advanced equipment at the defendant hospital, violated the Sherman Act §§ 1, 2. The plaintiffs alleged that twelve to fifteen percent of their patients were from out-of-state, and that these patients accounted for $100,000 in annual revenues. The

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plaintiffs further alleged that in the absence of the defendant's illegal activity, they would have another twelve to fifteen percent interstate patients, additional interstate revenues, and additional purchases of out-of-state medications. The court held that:

> "Interferences with the interstate travel of patients, the interstate payment of fees, and the interstate purchase of medication are well-recognized methods for demonstrating an effect on interstate commerce in antitrust litigation. We therefore conclude that plaintiffs' pleadings meet the jurisdictional requirements of the Sherman Act . . . ."

721 F.2d at 76 (citations omitted). In accord with the court's broad language in *Cardio-Medical*, Federal courts have relied upon the treatment of out-of-state patients, the receipt of Medicare, Medicaid, and out-of-state insurance funds, and the purchase of medicine, equipment, and medical supplies from out-of-state purveyors by the plaintiff doctor and/or the defendant hospital, to rule that the doctor's complaint satisfies the jurisdictional requirement of interstate commerce under the Sherman Act. *See, e.g., Weiss v. York Hospital*, Nos. 82-3507, 82-3580 & 82-3581, slip op. at 79-82, n.63 (3d Cir. September 27, 1984) (osteopath denied staff privileges); *Mishler v. St. Anthony's Hosp. Systems*, 694 F.2d 1225, 1227-28 (10th Cir. 1981) (neurosurgeon excluded from emergency room referral list); *Crane v. Intermountain Health Care, Inc.*, 637 F.2d 715, 725 (10th Cir. 1981) (en banc) (pathologist denied staff privileges); *Stone v. William Beaumont Hospital*, 1983-2 Trade Cases 69,475, 69,479 (E.D. Mich. 1983) (cardiologist denied staff privileges); *Konik v. Champlain Val. Physicians Hosp. Med. Ctr.*, 561 F. Supp. 700, 709-10 (N.D.N.Y. 1983), *aff'd*, 733 F.2d 1007 (2nd Cir. 1984) (anesthesiologist denied use of hospital facilities); *Pontius v. Children's Hospital*, 552 F. Supp. at 1361-62; (cardiovascular surgeon denied reappointment to staff); *McElhinney v. Medical Protective Co.*, 549 F. Supp. 121, 127-28 (E.D. Ky. 1982) (surgeon denied reappointment to staff); *Pao v. Holy Redeemer Hospital*, 547 F. Supp. 484, 489-90 (E.D. Pa.

1982) (opthalmologist denied staff privileges); *Everhart v. Jane C. Stormont Hospital*, 1982-1 Trade Cases 73,895, 73,896 (D. Kan. 1982) (cardiovascular surgeon denied staff privileges); *Williams v. Kleaveland*, 534 F. Supp. 912, 918 (W.D. Mich. 1981) (doctor denied reappointment to staff); *McDonald v. St. Joseph's Hospital of Atlanta*, 524 F. Supp. 122, 126-30 (N.D. Ga. 1981) (urological surgeon denied staff privileges); *Robinson v. Magovern*, 521 F. Supp. 842, 876 (W.D. Pa. 1981), *aff'd without opinion*, 688 F.2d 824 (3rd Cir.), *cert. denied*, 103 S. Ct. 302 (1982) (thoracic surgeon denied staff privileges); *Malini v. Singleton & Associates*, 516 F. Supp. 440, 442-43 (S.D. Tex. 1981) (radiologist denied staff privileges); *Feldman v. Jackson Memorial Hospital*, 509 F. Supp. 815, 819-21 (S.D. Fla. 1981) (podiatrist denied membership on medical staff).[15]

In the instant case, the plaintiffs' first amended complaint alleges that Dr. Marrese treats out-of-state patients; purchases medicine, equipment, and medical supplies from out-of-state purveyors; derives revenues from Medicare, Medicaid, and out-of-state private insurance companies; and pays management and accounting fees to out-of-state consultants. The plaintiffs' complaint further alleges that the impending revocation of Dr. Marrese's clinical privileges at Deaconness will prevent him from practicing orthopedic medicine in Evansville, Indiana or anywhere in the United States. Based upon

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[15] We note that courts have also dismissed doctors' claims under the Sherman Act, for the denial or revocation of hospital staff privileges, due to the plaintiff doctors' failure to allege a sufficient interstate commerce nexus. *See Hayden v. Bracy*, No. 83-2401, slip op. at 8-9 (8th Cir. September 27, 1984); *Furlong v. Long Island College Hosp.*, 710 F.2d 922, 927-28 (2d Cir. 1983); *Capili v. Shott*, 620 F.2d 438, 439 (4th Cir. 1980) (per curiam); *Wolf v. Jane Phillips Episcopal-Memorial Med. Ctr.*, 513 F.2d 684, 687-88 (10th Cir. 1975); *Moles v. Morton F. Plant Hospital, Inc.*, 1980-1 Trade Cases 77,186, 77,189-90 (M.D. Fla. 1978), *aff'd without opinion*, 617 F.2d 293 (5th Cir.), *cert. denied*, 449 U.S. 919 (1980).

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these allegations, and the Federal courts' expansive interpretation of the interstate commerce requirement under the Sherman Act, it may be that the plaintiffs can demonstrate a substantial and adverse effect upon interstate commerce as a matter of practical economics. At this point we cannot say beyond doubt that the plaintiffs will be unable to prove a set of facts that will establish this required effect upon interstate commerce.[16] It is true that at the time the plaintiffs filed their first amended complaint, Dr. Marrese's clinical privileges at Deaconess had not yet been revoked and thus, no substantial and adverse impact upon interstate commerce had yet occurred. The Supreme Court has stated, however, that jurisdiction is not defeated "by plaintiff's failure to quantify the adverse impact of defendant's conduct." *McLain*, 444 U.S. at 243.

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[16] In *Western Waste Service v. Universal Waste Control*, 616 F.2d 1094 (9th Cir.), *cert. denied*, 449 U.S. 869 (1980), the Ninth Circuit interpreted *McLain* to mean "that it was not necessary for the alleged antitrust violations complained of to have affected interstate commerce as long as *defendants'* business activities, independent of the violations, affected interstate commerce." 616 F.2d at 1097 (emphasis added). In *Crane v. Intermountain Health Care*, 637 F.2d at 724, the Tenth Circuit stated that "we do not believe *McLain* signals a shift in analytical focus away from the challenged activity and towards the defendant's general or overall business. The analytical focus continues to be on the nexus, assessed in practical terms, between interstate commerce and the challenged activity." In the instant case, we need not reach the issue of whether the plaintiffs could rely upon the interstate business activities of defendant, Deaconess Hospital, to satisfy the jurisdictional requirement of interstate commerce under the Sherman Act. *See Bunker Ramo Corp. v. United Business Forms, Inc.*, 713 F.2d at 1282 (this court does not find it necessary to choose between the various interpretations of *McLain*). Based upon the plaintiffs' allegations that Dr. Marrese treats out-of-state patients and has interstate purchases, revenues, and fees in excess of $500,000 annually, it may well be that the plaintiffs can demonstrate a substantial and adverse impact upon interstate commerce. *Accord Cardio-Medical Associates*, 721 F.2d at 76.

According to the Court, "[e]ven where there is an inability to prove that concerted activity has resulted in legally cognizable damages, jurisdiction need not be impaired, though such a failure may confine the available remedies to injunctive relief." *Id.* In light of the expansive interpretation of the interstate commerce requirement under the Sherman Act, and the fact that the plaintiffs seek injunctive relief under the Clayton Act § 16, we hold that the plaintiffs' first amended complaint alleges facts sufficient at the pleading stage of the proceeding to establish the jurisdictional requirement of interstate commerce under the Sherman Act, thus satisfying one of the two threshold issues before this court.

We hasten to note that our analysis of the plaintiffs' first amended complaint does not end with a determination of this jurisdictional issue of interstate commerce under the Federal antitrust laws. Rather a thorough reading of the plaintiffs' complaint reveals that the defendants' alleged conspiracy to "exclude DR. MARRESE from the Evansville, Indiana marketing area" was formulated and effectuated through the defendants' actions as members of or consultants to the hospital board, the SAHC, and the Medical Staff Executive Council at Deaconess. Indeed, the complaint alleges that "[i]n formulating and effectuating their ... conspiracy to eliminate plaintiffs as competitors in the relevant market and particularly for patients treated at the HOSPITAL, defendants further specifically agreed and conspired" in February 1978, to conduct an internal audit of the "back" procedures, including lumbar laminectomies and spinal fusions, performed at Deaconess; in August 1980, to retain Interqual, Inc. to conduct an independent audit of Dr. Marrese's surgical "back" procedures; to recommend, based upon the findings of the Interqual audit, that Dr. Marrese's clinical privileges be revoked; and in April 1982, on behalf of the Medical Staff Executive Council, to adopt the recommendation that Dr. Marrese's clinical privileges at Deaconess be revoked. Thus, according to the plaintiffs' first amended complaint, the defendants' alleged illegal

conduct under the Sherman Act consists of their actions as members of or consultants to the hospital board, the SAHC, and the Medical Staff Executive Council, in reviewing Dr. Marrese's surgical procedures and recommending that his clinical privileges at Deaconess be revoked. In effect, the plaintiffs' Federal antitrust lawsuit is an attack upon the defendants' overall conduct as participants in the medical peer review process at Deaconess Hospital and their motives in recommending that Dr. Marrese's clinical privileges be revoked.

In response to the allegations contained within the plaintiffs' first amended complaint, the focus of our analysis shifts to a review of the defendants' conduct in recommending that Dr. Marrese's clinical privileges be revoked. The plaintiffs' first amended complaint, dismissed in its entirety by the district court, clearly states that:

> "The professional staff of any hospital in the State of Indiana is *authorized*, pursuant to 31 [sic] Burns Indiana Statute 4-12-6(2)(c)(B) [Ind. Code 34-4-12.6-1(c)(2)] to establish a 'Peer Review Committee', which is a committee charged with the responsibility of evaluating the qualifications of professional health care providers at a hospital. DR. MARRESE is a 'professional health care provider' within the meaning of said statute.
>
> Defendant HOSPITAL attempted to implement the provisions of that statute on June 2, 1980 [sic] by adopting a 'Fair Hearing Plan'...."

(Emphasis added). As a result of the plaintiffs' factual assertions that Ind. Code § 34-4-12.6-1 authorizes hospitals to establish peer review committees to evaluate staff members' qualifications and that Deaconess Hospital acted to implement the provisions of that statute, we must consider the second threshold issue; whether the defendants' conduct is "clearly articulated and affirmatively expressed as [Indiana] state policy" and "actively supervised" by the State so as to be exempt from the Federal

antitrust laws under the doctrine of state action. *See Hoover v. Ronwin*, 104 S. Ct. 1989, 1995 (1984); *California Liquor Dealers v. Midcal Aluminum*, 445 U.S. 97, 105 (1980) ("*California Liquor Dealers*"). Such an analysis at the pleading stage of the proceeding is proper because the state action doctrine provides an *exemption* from the Federal antitrust laws and, if applicable, allows for dismissal of the complaint. *See, e.g., Hoover v. Ronwin*, 104 S. Ct. at 1994; *Gambrel v. Kentucky Board of Dentistry*, 689 F.2d 612, 613-21 (6th Cir. 1982), *cert. denied*, 103 S. Ct. 1198 (1983); *Benson v. Arizona State Bd. of Dental Examiners*, 673 F.2d 272, 274-76 (9th Cir. 1982).

We initially note that the district court, in dismissing the plaintiffs' first amended complaint, did not address the issue of state action. The general rule is that "a federal appellate court does not consider an issue not passed upon below." *Singleton v. Wulff*, 428 U.S. 106, 120 (1976); *Sharp v. Ford Motor Credit Co.*, 615 F.2d 423, 424 n.1 (7th Cir. 1980). It is clear, however, that the issue of state action has been addressed in the parties' briefs before this court and that "[t]he matter of what questions may be taken up and resolved for the first time on appeal is one left primarily to the discretion of the courts of appeals, to be exercised on the facts of individual cases." *Singleton v. Wulff*, 428 U.S. at 121.[17] In the instant case the plaintiffs challenge the defendants' conduct and motives as participants in the medical peer review process at Deaconess Hospital. A review of the plaintiffs' complaint along with the parties' briefs and the relevant Indiana statutory law reveals that the medical peer review process in the State of Indiana was developed and enacted by the Indiana legislature to regulate and improve the quality of medical care within the state. *See* Ind. Code. §§ 16-10-1-1 *et seq.*, 25-22.5-2-1 *et seq.*, 34-4-12.6-1 *et seq.* This com-

[17] On August 10, 1984, the parties were ordered to furnish the court with supplemental briefs, analyzing the applicability of the "state action" doctrine in the present case. The plaintiffs and defendants each submitted a supplemental and a reply brief on this issue.

prehensive statutory scheme mandates hospital medical staffs to review the professional practices and procedures of hospital staff members, *see* Ind. Code § 16-10-1-6.5, and authorizes the formation of peer review committees to perform this review process, *see* Ind. Code § 34-4-12.61(c). In light of this comprehensive statutory scheme in the State of Indiana, the plaintiffs' allegation that Deaconess Hospital acted to implement the provisions of this statutory scheme, and the fact that the state action doctrine *exempts* conduct that is "clearly articulated and affirmatively expressed as state policy" and "actively supervised" by the State from the Federal antitrust laws, this court is "justified in resolving [the state action] issue not passed on below . . . ." *Singleton v. Wulff*, 428 U.S. at 121.

The doctrine of state action originated in *Parker v. Brown*, 317 U.S. 341 (1943) ("*Parker*"), where a raisin producer in the State of California challenged a state statute that authorized "programs for the marketing of agricultural commodities produced in the state, so as to restrict competition among the growers and maintain prices in the distribution of their commodities to packers." 317 U.S. at 346. According to the Supreme Court, the program restricting the marketing of raisins in California:

> "derive[d] its authority and its efficacy from the legislative command of the state and was not intended to operate or become effective without that command. *We find nothing in the language of the Sherman Act or in its history which suggests that its purpose was to restrain a state or its officers or agents from activities directed by its legislature.* In a dual system of government in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its officers and agents is not lightly to be attributed to Congress."

Id. at 350-51 (emphasis added). *See also Hoover v. Ronwin*, 104 S. Ct. at 1995.

Since the seminal decision in *Parker*, the Supreme Court has further refined the doctrine of "state action." *See, e.g., Goldfarb v. Virginia State Bar*, 421 U.S. 773, 791 (1975) (state bar association's enforcement of a minimum legal fee schedule not exempt under *Parker* because not compelled by state); *Cantor v. Detroit Edison Co.*, 428 U.S. 579, 591-92 (1976) (opinion of Stevens, J.) (private utility company's regulation of light bulbs, approved by state and required to be continued until new tariff is filed, not exempt under *Parker*); *Bates v. State Bar of Arizona*, 433 U.S. 350, 362-63 (1977) (enforcement of clearly articulated disciplinary rules by state supreme court, acting in its legislative capacity, exempt under *Parker*); *Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 415 (1978) (opinion of Brennan, J.) (city's operation of electrical utility system exempt under *Parker* if state contemplated the action complained of when it authorized city to operate in that area); *New Motor Vehicle Bd. of Cal. v. Orrin W. Fox Co.*, 439 U.S. 96, 109 (1978) (state board's enforcement of a clearly articulated, affirmatively expressed state regulation of automobile dealerships is exempt under *Parker*); *California Liquor Dealers*, 445 U.S. at 105-06 (wine wholesaler's enforcement of a clearly articulated state system for wine pricing is not exempt under *Parker* because the state neither establishes nor reviews the price schedules, nor regulates the terms of fair trade contracts); *Community Communications Co. v. Boulder*, 455 U.S. 40, 55 (1982) (municipality's enforcement of its cable television ordinance is not exempt under *Parker* because the state's position is one of mere neutrality respecting the municipality's actions). Most recently, the Court in *Hoover v. Ronwin*, reaffirmed its rationale in *Parker* that "when a state legislature adopts legislation, its actions constitute those of the State . . . and *ipso facto* are exempt from the operation of the antitrust laws." 104 S. Ct. at 1995. The Court added that a "[c]loser analysis is required when the activity at issue is not directly that of the legislature . . .

but is carried out by others pursuant to state authorization." *Id.* It is "important to ensure that the anti-competitive conduct of the State's representative was contemplated by the State." *Id. See also Lafayette v. Louisiana Power & Light Co.*, 435 U.S. at 413-15 (opinion of Brennan, J.); P. Areeda, *Antitrust Law* ¶ 212.3 at 53-54 (Supp. 1982). According to the Court:

> "If the replacing of entirely free competition with some form of regulation or restraint was not authorized or approved by the State then the rationale of *Parker* is inapposite. As a result, in cases involving the anti-competitive conduct of a nonsovereign state representative the Court has required a showing that the conduct is pursuant to a 'clearly articulated and affirmatively expressed state policy' to replace competition with regulation. The Court also has found the degree to which the state legislature . . . supervises its representative to be relevant to the inquiry."

Hoover v. Ronwin, 104 S. Ct. at 1995 (citations omitted).[18] Thus, our review of the defendants' conduct in reviewing Dr. Marrese's surgical procedures and recommending that his clinical privileges at Deaconess be revoked is guided by the Supreme Court decisions, which "establish two standards for antitrust immunity under *Parker v. Brown*. First, the challenged restraint must be 'one clearly articulated and affirmatively expressed as state policy'; sec-

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[18] To satisfy the "clearly articulated and affirmatively expressed state policy" element of the state action doctrine, the state legislature must authorize the challenged activity and the legislature must intend to displace the Federal antitrust laws. *See* P. Areeda, *Antitrust Law* ¶ 212.3 at 53 (Supp. 1982). *See also Community Communications Co. v. Boulder*, 455 U.S. at 51-52; *Lafayette v. Louisiana Power & Light Co.*, 435 U.S. at 415 (opinion of Brennan, J.). The state legislature's intent to displace the federal antitrust laws exists if the challenged restraint is a necessary consequence of engaging in the authorized activity. P. Areeda, *Antitrust Law*, *supra*, at 54. *See also HyBud Equip. Corp. v. City of Akron*, No. 83-3306, slip op. at 19 (6th Cir. August 24, 1984).

ond, the policy must be 'actively supervised' by the State itself." *California Liquor Dealers*, 445 U.S. at 105 (quoting *City of Lafayette v. Louisianna Power & Light Co.*, 435 U.S. at 410 (opinion of Brennan, J.)).

At the outset, we note the underlying rationale of *Parker* that "the state action doctrine is grounded in concepts of federalism and state sovereignty." *Hoover v. Ronwin*, 104 S. Ct. at 1998 n.24 (citing *Community Communications Co. v. Boulder*, 455 U.S. at 54). Indeed, "the *Parker* exemption reflects the federalism principle that we are a Nation of *States*," *Community Communications Co. v. Boulder*, 455 U.S. at 50 (emphasis original), and "under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority," *Parker*, 317 U.S. at 351. This court's concern in resolving the state action issue is to preserve the principles of state sovereignty and federalism without disregarding the procompetitive, free enterprise values embodied in the Federal antitrust laws.[19] The presence of a clearly articulated and affirmatively expressed state policy, as well as active state supervision, reduces the "concern that federal policy is being unnecessarily and inappropriately subordinated to state policy." *Bates v. State Bar of Arizona*, 433 U.S. at 362. Moreover, the active supervision requirement "ensures that state-federal conflict will be avoided in those areas in which the state has demonstrated its commitment to a program through its exercise of regulatory oversight." 1 P. Areeda & D. Turner, *Antitrust Law* ¶ 213a at 73 (1978). We add that in the instant case, a further concern of this court is to promote the intended purpose of the Sherman Act as a "consumer welfare prescription." *NCAA v. Board of Re-*

[19] *See, e.g.*, S. Sachs, *Antitrust, The States, and The Professions*, 52 Antitrust L.J. 189, 191-92 (1983) (professional areas create a potential tension between Federal antitrust laws and states' legitimate interest in regulation); D. Smith, *Antitrust Immunity for State Action: A Functional Approach*, 31 Baylor L. R. 263, 289-92 (1979) (state action doctrine is an accommodation of potentially competing sovereigns).

gents of Univ. of Okla., 104 S. Ct. 2948, 2964 (1984) (quoting *Reiter v. Sonotone Corp.*, 442 U.S. 330, 343 (1979)). *See also Indiana Federation of Dentists v. F.T.C.*, No. 83-1700, slip op. at 30 (October 11, 1984); R. Bork, *The Antitrust Paradox* 66 (1978); 21 Cong. Rec. 2455, 2456-63 (March 21, 1890) (statement of Sen. Sherman). The State of Indiana has developed and enacted a comprehensive statutory scheme of medical peer review to protect consumer welfare. Indeed, the State's medical peer review process ensures Indiana citizens of the highest quality of medical care, while protecting them from incompetent, unqualified medical treatment. It is within this framework that we analyze the comprehensive statutory scheme developed and enacted by the Indiana legislature to establish, regulate, and supervise the medical peer review process within the State.[20]

Our initial inquiry is whether the defendants' review of Dr. Marrese's surgical "back" procedures at Deaconess and the recommendation that his clinical privileges be revoked is conduct "clearly articulated and affirmatively

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[20] In the instant case, our state action analysis is, by necessity, limited to a review of the Indiana statutory scheme regulating the medical peer review process. We note, however, that peer review is mandated by Congress when medical services are paid for with Medicare, *see* 42 U.S.C. § 1395x(k),(r),(s) (1982), and/or Medicaid, *see* 42 U.S.C. § 1396a(a)(19),(26) (1982), funds, and also when hospitals seek certification for participation in the Medicare program by obtaining accreditation from the Joint Commission for the Accreditation of Hospitals, *see* 42 U.S.C. § 1395bb(a) (1982). It is clear that Congress, by mandating hospital staff members or members of the local medical society to participate in the peer review process, *see* 42 U.S.C. § 1395x(k)(2), accepts the potential anticompetitive effects of the medical peer review process in favor of quality medical care. *See* 49 Fed. Reg. 14977 (1984) (proposed rules to protect information of Peer Review Organizations); 49 Fed. Reg. 29026 (1984) (revised rules for Peer Review Organizations). *Cf. Pontius v. Children's Hospital*, 552 F. Supp. at 1376 (Congress has attempted to improve the process of peer review through the Peer Review Improvement Act, 42 U.S.C. §§ 1320c-1 *et seq.* (1984)).

expressed as [Indiana] state policy." The Indiana statutory scheme clearly mandates that:

> "The governing board of the hospital *shall* be the supreme authority in the hospital, responsible for . . . the appointment of members of the medical staff and the assignment of privileges to members of the medical staff with the advice and recommendations of the medical staff consistent with their individual training, experience, and other qualifications. The medical staff of a hospital shall be an organized group which . . . *shall* have the responsibility of reviewing the professional practices in the hospital for the purpose of reducing morbidity and mortality, and for the improvement of the care of patients in the hospital. This review shall include, but shall not be limited to, the quality and necessity of the care provided patients . . . ."

Ind. Code § 16-10-1-6.5 (emphasis added).[21] To implement this review process, the statutory scheme provides that

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[21] Similarly, the administrative regulations of the Indiana Hospital Licensing Board provide that:

> "THE GOVERNING BODY. The governing board of the hospital shall be the supreme authority in the hospital, responsible for the management, operation, functioning, and control of the hospital. The Governing Body shall:
>
> * * *
>
> (g) Approve the bylaws, rules, and regulations of the Medical Staff and audit procedures or other measures used to assure quality of care.
>
> (h) Appoint members of the Medical Staff and assign privileges consistent with their individual training, experience, and other qualifications on a periodic basis (at least every two (2) years) with the advice and recommendations of the organized Medical Staff."

410 Ind. Adm. Code 15-1-5 (Cumm. Supp. 1983). Furthermore:

(Footnote continued on following page)

hospitals establish a peer review committee that shall have "the responsibility of evaluation of qualifications of professional health care providers, or of patient care rendered by professional health care providers, or of the merits of a complaint against a professional health care provider that includes a determination or recommendation concerning the complaint." Ind. Code § 34-4-12.6-1. The peer review committee must be organized, *inter alia*, " by the professional staff of a hospital" and a "majority of the members [must be] professional health care providers holding licenses in the stated profession of the committee." *Id.*

The plaintiffs admit that Deaconess Hospital has "attempted to implement the provisions" of Ind. Code 34-4-12.6-1 *et seq.* Additionally, the plaintiffs allege that the SAHC and the Executive Council at Deaconess were organized by the hospital and consisted of a majority of licensed doctors (seven doctors, one hospital adminis-

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[21] *continued*

"THE MEDICAL STAFF. (1) The Medical Staff of a hospital composed of two (2) or more physicians shall be an organized group which shall be responsible to the governing board for the clinical and scientific work of the hospital, advise regarding professional matters and policies to the governing board, or the board's designee, and shall have the responsibility of reviewing the professional practices in the hospital for the purpose of reducing morbidity and mortality, and for the improvement of the care of patients in the hospital. This review shall include, but shall not be limited to, the quality and necessity of the care provided patients and the preventability of complications and deaths occurring in the hospital.

(2) The medical staff shall initiate and, with the approval of the Governing Body, adopt and periodically amend bylaws, rules, regulations, and policies which shall include, but need not be limited to, provisions for:

(a) Qualifications to be met for appointment to staff membership and for delineation of privileges.

(Footnote continued on following page)

trator, and one attorney). The record reveals that the medical staff at Deaconess Hospital has acted pursuant to Ind. Code § 34-4-12.6-1, to establish a peer review process that complies with the requirements of Ind. Code § 34-4-12.6-1(c). The State of Indiana has "clearly articulated and affirmatively expressed as state policy" that hospital medical staffs are to form peer review committees and that such committees are to review the quality and necessity of the care provided patients, to evaluate the qualifications of staff members, and review the merits of any recommendation against a staff member. Ind. Code §§ 16-10-1-6.5, 34-4-12.6-1. As a necessary and reasonable consequence of this state mandated medical peer review process, hospital staff members must review the medical treatments, diagnostic procedures, and surgical procedures of competing staff members and, when required, recommend the revocation of staff privileges. Thus, the defendants' conduct, as members of or consultants to the hospital board, the SAHC, and the Medical Staff Executive Council, in reviewing Dr. Marrese's surgical procedures and recommending that his staff privileges be revoked, satisfies the first element of the *Parker* test. *See* Borsody & Tiano, *Peer Review and the Anti-Trust Laws: An Analysis and a Proposal*, 26 St. Louis U.L.J. 511, 514-15 (1982).

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[21] *continued*

* * *

(d)(1) Review of applications for staff membership, delineation of privileges, and recommendations on appointment to the Governing Body.

(2) Appeal of decisions regarding Medical Staff membership and privileges.

(3) Review and analysis, at regular stated intervals, of clinical performance, pathological reports, the completeness of medical records and of the enforcement of requirements related thereto, of infection control, of use of blood and blood-related elements, and of total patient care.

410 Ind. Adm. Code 15-1-7 (Cumm. Supp. 1983).

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We turn our attention to the second element of the *Parker* test, whether the State of Indiana "actively supervises" the medical peer review process. The Indiana statutory scheme provides that the Indiana Medical Licensing Board shall, *inter alia*, promulgate rules and regulations necessary for the licensing of doctors within the state and also "[a]dopt rules establishing standards for the competent practice of medicine or osteopathic medicine, or any other form of practice regulated by a limited license or permit issued [by the Board]." Ind. Code § 25-22.5-2-7(h) (1982). The Medical Licensing Board, created by the Indiana legislature, consists of five physicians, one osteopathic physician, and one lay member of the general public, all appointed by the Governor. The Board closely supervises the Indiana medical profession by requiring that every physician within the state biennially register and qualify for licensure by the Board. 844 Ind. Adm. Code 4-6-1 *et seq.* (Cumm. Supp. 1983). Pursuant to Ind. Code § 25-22.5-6-2.1, the Board is authorized to commence revocation proceedings to revoke or suspend the medical license of any practitioner who knowingly violates the rules of competent medical practice established and promulgated by the Board. In furtherance of this duty to regulate the Indiana medical profession, the Board reviews the communications, records, and determinations of hospital peer review committees. According to the Indiana statutory scheme:

> "Communications to, and the records and determinations of, a peer review committee may only be disclosed to the specific credentials committee of a hospital or other health facility, the disciplinary authority of the professional organization of which the professional health care provider under question is a member, or *the appropriate state board of registration and licensure* which the committee deems necessary for recommended disciplinary action . . . ."

Ind. Code § 34-4-12.6-2(b) (emphasis added).[22] Thus, the Indiana legislature has created the Indiana Medical Licensing Board as an official body of the State to promulgate and enforce standards of competent medical practice, regulate the licensing of doctors within the State, and review the confidential communications, records, and determinations of medical peer review committees. The examination of confidential peer review data and records is an essential element of the Board's function in regulating the medical profession and in assuring that the citizens of Indiana receive the highest quality of medical care.

In addition, the Indiana statutory scheme provides that the State Board of Health shall license and regulate hospitals within the State through the Hospital Licensing Council. Ind. Code §§ 16-10-1-1, 16-10-1-3. Pursuant to Ind. Code § 6-10-1-12, the Council shall promulgate rules and regulations pertaining to the proper operation and management of hospitals within the State, amend rules and regulations "for the establishment and maintenance of standards of hospitalization required for the efficient care of patients," and prescribe, through rules and regulations, "the minimum standards as to equipment and provision for the care of patients to which an institution must conform in order to operate lawfully as a hospital" within the State. The Hospital Licensing Council, just as the Medical Licensing Board, is a creature of the Indiana

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[22] Similarly, the Indiana legislature amended Ind. Code § 16-10-1-6.5, effective April 22, 1983, to require that:

> "The governing board shall report, in writing, to the Indiana medical licensing board the results and circumstances of any final, substantive, and adverse disciplinary action taken by the governing board regarding a physician on the medical staff, or an applicant for the medical staff, if the action results in voluntary or involuntary resignation, termination, nonappointment, revocation, or significant reduction of clinical privileges or staff membership."

Ind. Code Ann. § 16-10-1-6.5(b) (Burns Supp. 1983).

legislature and consists of one physician, one registered nurse, four hospital administrators, one member of the Indiana Department of Public Welfare, and one member of the State Board of Health, all appointed by the Governor. Ind. Code § 16-10-1-3. The Council continually reviews the operation of hospitals within the State and, based upon its compiled data, recommends to the State Board of Health whether or not a hospital qualifies for annual license renewal. Ind. Code § 16-10-1-9. According to the Indiana statutory scheme, representatives of the State Board of Health are required to review all hospitals within the state on a periodic basis, Ind. Code § 16-10-1-13, and the Hospital Licensing Council is authorized to employ field inspectors to inspect hospitals and "give advice, aid, and encouragement to such institutions, in maintaining high professional ideals and good care of patients." Ind. Code § 16-10-1-17. Pursuant to 410 Ind. Adm. Code 15-1-8(1)(c) (1979), these field inspectors are entitled to review the confidential minutes of meetings of the hospital board, the medical staff, and the medical staff peer review committees. Included within the confidential minutes of peer review meetings are records of staff membership applications, delineations of staff privileges, appeals of decisions regarding medical staff membership and privileges, and records of clinical performance and total patient care within the hospital. 410 Ind. Adm. Code 15-1-7(d), (f). Thus, the Hospital Licensing Council of the Indiana State Board of Health is an official body created by the Indiana legislature to promulgate and enforce the proper standards of hospital care and regulate the licensing and operation of hospitals within the State. As an integral part of its hospital inspection program, the Council reviews the confidential communications, records, and determinations of medical peer review committees, assuring Indiana citizens that hospital medical staffs are providing quality medical care while acting in accordance with approved medical standards.

In *California Liquor Dealers*, the Supreme Court analyzed the nature of the supervision that a state must

exercise over a nonsovereign state representative to satisfy the second element of the *Parker* test. In that case the State of California had a plan for wine pricing that constituted resale price maintenance in violation of the Sherman Act. The defendant, a wholesaler of California wines, argued that his enforcement of the wine pricing system was exempt from the Federal antitrust laws under the doctrine of state action. The Supreme Court held that the resale plan was "clearly articulated and affirmatively expressed as state policy" because "[t]he legislative policy is forthrightly stated and clear in its purpose to permit resale price maintenance." *California Liquor Dealers*, 445 U.S. at 105. The Court added, however, that the plan "does not meet the second requirement for *Parker* immunity. The State simply authorizes price setting and enforces the prices established by private parties. The State neither establishes prices nor reviews the reasonableness of the price schedules; nor does it regulate the terms of fair trade contracts." *Id.* at 105-06.

As contrasted to the facts in *California Liquor Dealers*, the State of Indiana, through the Indiana Medical Licensing Board, enacts, promulgates, and enforces rules of competent medical practice within the State and reviews the confidential records of medical peer review committees to determine if further action is required. This Medical Licensing Board, acting on behalf of the State's interest in protecting the health and ensuring the safety of Indiana citizens, closely supervises the Indiana medical profession and with the assistance of medical peer review committees, regulates the licensing of physicians within the State. Moreover, the State of Indiana, through the Hospital Licensing Council, promulgates standards of proper hospital care, regulates the licensing of hospitals within the State, and, as an integral part of its hospital inspection program, reviews the confidential records of medical peer review committees. In light of the Medical Licensing Board's active supervision of the medical profession and the Hospital Licensing Council's active supervision of hospitals and their medical staffs, it is clear that the State of Indiana ensures its citizens of quality medical

care and "actively supervises" the medical peer review process within the State. Thus, the defendants' conduct, as members of or consultants to the hospital board, the SAHC, and the Medical Staff Executive Council, in reviewing Dr. Marrese's surgical procedures and recommending that his staff privileges be revoked satisfies the second element of the *Parker* test.

Furthermore, the Indiana statutory scheme provides that:

> "The members of any medical staff committee organized for the purpose of conducting medical review, being retrospective and not a part of current patient care, shall have an absolute immunity from civil liability for communications made in committee meetings, and reports and recommendations made by the committee arising from deliberations by the committee to the governing board of the hospital or another duly authorized medical staff committee."

Ind. Code § 16-10-1-6.5.[23] Similarly, Ind. Code. § 34-4-12.6-3 provides that:

> "There shall be no liability on the part of, and no action of any nature shall arise against, the personnel of a peer review committee for any act, statement made in the confines of the committee, or proceeding thereof made in good faith in regard to evaluation of patient care

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[23] The Indiana legislature amended § 16-10-1-6.5, effective April 22, 1983, to provide that:

> "The governing board and its employees, agents, consultants, and attorneys have absolute immunity from civil liability for communications, discussions, actions taken, and reports made concerning disciplinary action or investigation taken or contemplated, if such reports or actions are made in good faith and without malice."

Ind. Code Ann. § 16-10-1-6.5 (Burns Supp. 1983).

• • •

> The personnel of a peer review committee shall be immune from any civil action arising from any determination made in good faith in regard to evaluation of patient care . . . ."

This immunity from civil liability afforded members of the medical peer review process is in accord with the court's reasoning in *Pontius v. Children's Hospital*, that subjecting members of the peer review process to a Federal antitrust lawsuit will "chill the rights and obligations of physicians to participate in peer review." 552 F. Supp. at 1376. According to that court:

> "if *individual physicians*, who manage to overcome their traditional reluctance to testify about the professional conduct of a colleague, know that by so doing they risk incurring legal fees running into six figures and a trial of a duration measured in months, on the mere allegation that they have conspired to restrain trade, the discovery of incompetent physicians will be rendered extraordinarily difficult."

Id. at 1362 (emphasis original).

It is only logical that physicians within the State of Indiana, when presented with allegations of Federal antitrust violations and the threat of treble damages, will either dilute their peer review reports and cease recommending the revocation of a hospital staff member's privileges or will discontinue their participation in the state mandated and supervised peer review process. As a result, the very lifeline of the medical peer review process will be severed. Indeed, as the Supreme Court observed in *Hoover v. Ronwin*, with regard to the legal profession and a committee of State Bar Examiners, "[t]here can be no question that the threat of being sued for [treble] damages [under the Sherman Act] particularly where the issue turns on subjective intent or motive—will deter 'able citizens' from performing [an] essential public service." 104 S. Ct. at 2002 n.34. Similarly in the medical profession, the threat of a Federal antitrust lawsuit will compel able

and qualified physicians, with particular expertise in complex areas of medicine, to abdicate their participation in the medical peer review process. The overall effect will be to destroy the intended purpose of medical peer review; to assure Indiana citizens of quality medical care and protect them from incompetent, unqualified medical treatment.

In the context of an academic setting this court recently stated that:

> "the peer review process is essential to the very lifeblood and heartbeat of academic excellence and plays a most vital role in the proper and efficient functioning of our nation's colleges and universities. The process of peer evaluation has evolved as the best and most reliable method of promoting academic excellence and freedom by assuring that faculty tenure decisions will be made objectively on the basis of frank and unrestrained critiques and discussions of a candidate's academic qualifications."

E.E.O.C. v. University of Notre Dame Du Lac, 715 F.2d 331, 336 (7th Cir. 1983). So too, peer review is essential to the very lifeblood and heartbeat of medical competency and quality medical care in the State of Indiana and throughout the nation. In furtherance of this policy, the Indiana statutory scheme provides that "a committee having the responsibility of evaluation of qualifications of professional health care providers, or of patient care rendered by professional health care providers, or of the merits of a complaint against a professional health care provider" shall be immune from any civil action arising from a determination made in good faith. Ind. Code §§ 34-4-12.6-1, 34-4-12.6-3. Though this immunity attaches only after a finding that the committee's determinations were made in good faith, the concept to be gleaned from Ind. Code §§ 16-10-1-6.5 *et seq.*, 34-4-12.6-1 *et seq.* is that the State of Indiana realizes the real threat of lawsuits arising from the revocation of hospital staff privileges and has acted to protect the personnel involved in the medical peer review process. This protection encourages competent and qualified physicians to participate in the medical peer review process, thus assuring the

citizens of Indiana that hospital medical staffs are competent, qualified, and practicing in accord with approved medical standards. The "good faith" immunity provision is an essential element of the state mandated and supervised peer review process in the State and, in conjunction with the other provisions of the comprehensive statutory scheme, it furthers the underlying policy of the Sherman Act to protect consumer welfare.

We further note that under the Indiana statutory scheme any practitioner investigated by a medical peer review committee shall receive the due process safeguard of an evidentiary hearing before any disclosure of the committee's findings. Pursuant to Ind. Code § 34-4-12.6-2:

> "Any professional health care provider under investigation shall be permitted at any time to see any records accumulated by a peer review committee pertaining to his personal practice and shall be offered the opportunity to appear before the peer review committee with adequate representation to hear all charges and findings concerning his practice and to offer rebuttal information, which shall be a part of the record before any disclosure of the charges and findings . . . ."

According to the Fair Hearing Plan at Deaconess, any practitioner adversely affected by a recommendation of the Medical Staff Executive Council has a right to an evidentiary hearing and, if necessary, a review before the joint conference committee of the hospital. The practitioner may request to be represented by an attorney and/or be accompanied by a member of the medical staff. In addition he shall be allowed to introduce evidence, examine witnesses, and be on record throughout the entire hearing process. Moreover, if the hospital board, upon completion of the hospital hearings, adopts the Medical Staff Executive Council's recommendation of suspension or revocation, the practitioner may appeal that final decision, challenge the hospital staff members' "good

faith" in reaching that decision, and challenge the Fair Hearing Plan on constitutional grounds, through the Indiana state court system. *See Kiracofe v. Reid Memorial Hosp.*, ____ Ind. App. ____, 461 N.E.2d at 1139-41; *Yarnell v. Sisters of St. Francis Hlth. Serv.*, ____ Ind. App. ____, 446 N.E.2d at 361-63. *See also, Renforth v. Fayette Memorial Hospital Ass'n.*, 178 Ind. 475, 489, 383 N.E.2d 368, 377 (1978) (en banc), *cert. denied*, 444 U.S. 930 (1979). In the instant case, it is clear that before his clinical privileges at Deaconess hospital are revoked, Dr. Marrese is entitled to the due process safeguards of a hearing and a review before the joint conference committee of the hospital. In the event that the hospital board adopts the recommendation of the Medical Staff Executive Council and revokes Dr. Marrese's clinical privileges, he is entitled to a complete review of that decision and all its proceedings within the Indiana state court system.

In light of the hearings provided by the Fair Hearing Plan at Deaconess, and the availability of the Indiana state courts to appeal an adverse decision of the hospital board, it is clear that the plaintiffs have a more than adequate forum to challenge the defendants' conduct and motives in reviewing Dr. Marrese's surgical procedures and in recommending that his clinical privileges at Deaconess be revoked. The plaintiffs' Federal antitrust lawsuit, attacking the defendants' conduct as members of the peer review process at Deaconess and challenging their motives in recommending that Dr. Marrese's clinical privileges be revoked, circumvents the hospital hearings and the state court review process in favor of a Federal forum. It is well recognized that "federal courts . . . are now straining under excessive caseloads." *Patsy v. Florida Board of Regents*, 457 U.S. 496, 517 (1982) (O'Connor, J., concurring). As a matter of judicial economy,[24] the

[24] We here note Judge Fairchild's separate view that judicial economy is irrelevant in this context. As he sees it, our decision

(Footnote continued on following page)

Federal courts must not be further burdened by complex antitrust litigation when the alleged illegal conduct is mandated and supervised by the state and, furthermore, the plaintiff is afforded the due process safeguards of hearings and state court review. Common sense dictates that a cause of action under the Sherman Act is not created every time a lawyer, accountant, or architect is denied partnership status in a national firm, a business executive is fired or denied a promotion by a national corporation, or a physician, surgeon, or specialist has hospital staff privileges denied or revoked. In the instant case, Dr. Marrese is entitled to challenge the defendants' motives and conduct in a hearing before the Deaconess medical staff, a review hearing before the joint conference committee of the hospital, and finally through proceedings in the Indiana state court system. Just as a disgruntled state bar applicant who is denied admission to a state bar has no cause of action under the Sherman Act against a state mandated and supervised bar review committee, *Hoover v. Ronwin*, 104 S. Ct. at 2001, Dr. Marrese has no cause of action under the Sherman Act against the defendants as participants in the state mandated and supervised medical peer review process. Instead, Dr. Marrese must challenge the defendants' conduct and motives through the proper forums; the hospital hearing committees and the Indiana state court system.

Finally, we note the proviso of the court in *Pontius v. Children's Hospital*, that:

> "If a physician, terminated from hospital privileges after receiving due process, is able to force the hospital to assume the burdens of an antitrust trial on the mere

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[24] *continued*

is an interpretation of the state action doctrine of Federal antitrust law. Our conclusion that the doctrine applies to the present situation does, of course, result in relieving the district court of this lawsuit, but in his view achievement of that result is not an appropriate consideration in reaching our conclusion.

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> allegation that the hospital's decision was grounded on reasons violative of the Sherman Act, the ability of hospitals to regulate their medical staffs will be seriously impaired."

552 F. Supp. at 1362. The evident trend among an increasing number of state supreme courts is to find that a hospital's "failure to investigate a medical staff applicant's qualifications for the privileges requested gives rise to a foreseeable risk of unreasonable harm and [thus] a hospital has a duty to exercise due care in the selection of its medical staff." *Johnson v. Misericordia Community Hosp.*, 99 Wis.2d 708, 723, 301 N.W.2d 156, 164 (Wis. 1981) and cases cited therein. *See also Vuciecevic v. MacNeal Memorial Hosp.*, 572 F. Supp. 1424, 1428 (N.D. Ill. 1983); Annot., 51 A.L.R. 3d 981 (1973). Indeed, according to the court in *Johnson v. Misericordia Community Hosp.*:

> " 'One of the hospital's primary functions is to screen its staff of physicians to "insure" that only competent physicians are allowed to practice in the hospital.'
>
> * * *
>
> Obviously, the promotion of quality care and treatment of patients requires hospitals to perform a thorough evaluation of medical staff applicants from the standpoint of professional competence, ethics, established reputation, and further, to periodically review the qualifications of its staff through a peer review or medical audit mechanism. Hospitals, like doctors, must, above all else, be concerned with the welfare of their patients and must establish basic procedures to prevent subjecting them to harm and injury by physicians and surgeons who fail to possess an adequate level of technical skill, competence and ethical principles."

99 Wis.2d at 732, 734-35, 301 N.W.2d at 168-70 (quoting *Ferguson v. Gonyaw*, 64 Mich. App. 685, 697, 236 N.W.2d 543, 550 (1976)). *Cf. Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 104 S. Ct. 1551, 1568 (1984) ("hospital's unquestioned right to exercise some control over the identity and the

number of doctors to whom it accords staff privileges").

In the instant case, the State of Indiana's comprehensive statutory scheme, mandating and supervising the medical peer review process, enables the hospitals to fulfill their common law duty of exercising due care in selecting and maintaining a qualified and competent medical staff and, as a result, assures Indiana citizens that medical practices and procedures within the State are being closely monitored and reviewed. An attack upon this state mandated and supervised peer review process, through the Federal antitrust laws, will compel able and qualified physicians to abdicate their participation in the review of hospital staff members. This, in turn, will destroy the medical peer review process and prevent hospitals from fulfilling their duty to provide patients with a competent medical staff. In addition, the expenses in time and money, incurred by hospitals and physicians in defending their actions, as members of the state mandated and supervised medical peer review process, against the Federal antitrust laws, will eventually be reflected in increased medical costs to the consumer. Accordingly, we are reluctant to further burden the Federal courts with a greater influx of complex antitrust litigation, when a state such as Indiana in the instant case, clearly articulates and affirmatively expresses a state policy mandating medical peer review; actively supervises peer review committees' communications, records, and determinations through the Medical Council; enacts legislation to assure an adversely affected practitioner that he will receive the due process safeguard of an evidentiary hearing within the hospital; and provides the adversely affected practitioner with a state court forum to challenge the conduct and motives of participants in the peer review process.

Based upon the foregoing analysis it is apparent that the State of Indiana has established a thorough peer review process to assure the citizens of Indiana that only competent and qualified physicians, who practice only approved methods of medical care, are licensed within the state. True, the members of a peer review committee, as trained experts in highly specialized fields of medicine, are

often in direct competition with the practitioner whom they are reviewing, and the committee's decision to revoke hospital staff privileges may conceivably have a "substantial and adverse effect" upon interstate commerce. Nonetheless, "we are a Nation of *States*" *Community Communications Co. v. Boulder*, 455 U.S. at 50 (emphasis original), and "under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority," *Parker*, 317 U.S. at 351. "The Sherman Act . . . gives no hint that it was intended to restrain . . . official action directed by a state." *Parker*, 317 U.S. at 351. There is "nothing in the language of the Sherman Act or in its history which suggests that its purpose was to restrain a state or [its nonsovereign representatives] from activities directed by its legislature." *Id.* at 350-51. In fact, the purpose of the Sherman Act is to protect consumer welfare.

The State of Indiana has made a policy decision that the peer review process is necessary to protect the citizens of Indiana and promote consumer welfare. It runs contrary to the very concepts of state sovereignty and federalism for a Federal court to review the conduct of a peer review committee, under the guise of the Sherman Act, when the State of Indiana: mandates that hospital medical staffs review the quality and necessity of care provided patients; establishes a peer review process to assure for a competent medical staff throughout the State; immunizes members of a peer review committee, who act in good faith, from civil liability; creates a Medical Licensing Board and a Hospital Licensing Council to enforce rules of medical competence and review the actions of medical peer review committees; provides adversely affected practitioners with the due process safeguards of an evidentiary hearing; and provides adversely affected practitioners with a state court forum to challenge the conduct and motives of participants in the peer review process. In the instant case, the defendants' actions in reviewing Dr. Marrese's surgical procedures and in recommending that his clinical privileges be revoked are "clearly articulated and affirmatively expressed as state policy" and are "ac-

tively supervised" by the State. Thus, in light of the plaintiffs' allegations that the defendants alleged illegal conduct consists solely of their actions as members of or consultants to the hospital board, the SAHC, and the Medical Staff Executive Council, acting within the Indiana medical peer review process, we hold that the defendants' actions are exempt from the Federal antitrust laws under the doctrine of state action.[25]

III

Accordingly, we affirm the district court's dismissal of the plaintiffs' complaint.

A true Copy:
Teste:

.....
Clerk of the United States Court of Appeals for the Seventh Circuit

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[25] We are cognizant of the district court's ruling that the plaintiffs did not allege sufficient "state action" to state a cause of action under 42 U.S.C. § 1983. The plaintiffs did not appeal the district court's dismissal of their claim under 42 U.S.C. § 1983 nor was this court presented with any argument on the issue. We note that the elements required for a cause of action under 42 U.S.C. § 1983, a "deprivation . . . caused by the exercise of some right or privilege created by the State" and "the party charged with the deprivation must be a person who may fairly be said to be a state actor," *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 937 (1982) differ from the elements required for state action under *Parker*. We further note that the Fair Hearing Plan at Deaconess Hospital provides Dr. Marrese with the due process safeguard of an evidentiary hearing and, if necessary, a review hearing before the joint conference committee of the hospital. Moreover, if Dr. Maresse's clinical privileges at Deaconess are, in fact, revoked, the hospital's decision can be appealed through the Indiana state court system.

USCA 50234—Pandick Midwest, Inc., Chicago—11-6-84—450

UNITED STATES COURT OF APPEALS

For the Seventh Circuit

Chicago, Illinois 60604

(Argued March 29, 1984)

August 10, 1984

Hon. WILLIAM J. BAUER, *Circuit Judge*
Hon. JOHN L. COFFEY, *Circuit Judge*
Hon. THOMAS E. FAIRCHILD, *Senior Circuit Judge*

R. ANTHONY MARRESE, M.D. and BONE & JOINT SURGEONS, INC., *Plaintiffs-Appellants,*

No. 83-1581 *vs.*

INTERQUAL, INC., et al., *Defendants-Appellees.*

Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.

No. 82 C 4296
George N. Leighton, *Judge.*

ORDER

The parties have adequately briefed the issue of whether the plaintiffs' complaint alleged sufficient facts to satisfy the jurisdictional requirement of interstate commerce under the Sherman Act. A second issue of law has been addressed in the briefs as to whether the defendants' conduct, as members of the medical peer review process in Indiana, is exempt from the Federal antitrust laws under the doctrine of state action. A majority of this panel has decided that additional briefing of this state action issue would be beneficial before a final decision is rendered.

Accordingly, IT IS ORDERED that the parties shall have 30 days from the date of this order to simultaneously submit their respective supplemental brief on the state action issue. Thereafter the parties shall have 15 days to simultaneously

submit a reply brief if they so desire. There will be no oral argument unless requested by the court.

The supplemental briefs shall address the issue of whether revocation of hospital staff privileges gives rise to a cause of action under the Sherman Act in light of Indiana's comprehensive statutory scheme regulating the medical peer review process. See Ind. Code §§ 16-10-1-1 *et seq.* 25-22.5-2-1 *et seq.* and 34-4-12.6-1 *et seq.* The briefs shall also fully discuss the issue of whether anticompetitive or other invidious motivation, as alleged in the plaintiffs' complaint, is relevant to the establishment of a Sherman Act cause of action in this case.

UNITED STATES COURT OF APPEALS

For the Seventh Circuit

Chicago, Illinois 60604

December 27, 1984

Before

Hon. WILLIAM J. BAUER, *Circuit Judge*
Hon. JOHN L. COFFEY, *Circuit Judge*
Hon. THOMAS E. FAIRCHILD, *Senior Circuit Judge*

R. ANTHONY MARRESE, M.D., and BONE & JOINT SURGEONS, INC., *Plaintiffs-Appellants,*

No. 83-1581 *vs.*

INTERQUAL, INC., et al., *Defendants-Appellees.*

Appeal from the United States District Court for the Northern District of Illinois Eastern Division.

No. 82 C 4296
George N. Leighton, *Judge.*

ORDER

On consideration of the petition for rehearing and suggestion for rehearing *en banc* filed in the above-entitled cause by the plaintiffs-appellants, no judge in active service has requested a vote thereon, and all of the judges on the original panel have voted to deny a rehearing. Accordingly,

IT IS ORDERED that the aforesaid petition for rehearing be, and the same is hereby, DENIED.

Received
July 29, 1982
N. Stuart Cunningham
United States District Court

IN THE UNITED STATES DISTRICT COURT

For the Northern District of Illinois

Eastern Division

R. ANTHONY MARRESE, M.D., et al, *Plaintiffs,* v. INTERQUAL, INC., et al, *Defendants.*	No. 82 C 4296

NOTICE OF FILING

PLEASE TAKE NOTICE that, pursuant to Rule 15(a), Federal Rules of Civil Procedure, we caused to be filed with the Clerk of the United States District Court, for the Northern District of Illinois, Eastern Division, this 26th day of July, 1982, the attached First Amended Complaint.

R. ANTHONY MARRESE, M.D. and
BONE & JOINT SURGEONS, INC.

By: /s/ LANDESMAN & SCHWARTZ,
Landesman & Schwartz,
Their Attorneys

JOHN J. CASEY
LANDESMAN & SCHWARTZ
111 W. Washington St.
Suite 1025
Chicago, IL 60602
(312) 346-6650

IN THE UNITED STATES DISTRICT COURT

For the Northern District of Illinois

Eastern Division

R. ANTHONY MARRESE, M.D. and BONE & JOINT SURGEONS, INC., an Indiana corporation

Plaintiffs,

vs.

INTERQUAL, INCORPORATED, a Delaware corporation,

and

DEACONESS HOSPITAL, an Indiana not-for-profit corporation,

and

WILLIAM H. ALLEN, M.D., BRYANT A. BLOSS, M.D. THOMAS EVANS, M.D., AHMET K. PERCINEL, M.D., PEDRO DOMINQUEZ, M.D., SAM B. BAKER, M.D., KENNETH NACHTNEBEL, M.D., DAVID A. JOHNSON and JOHN RENDER,

and

C. LE ROY ANDERSON, DAVID L. BARNING, C. JACKSON BUSCHKILL, MRS. JEAN G. DREMSTEDT, GERALD M. FINNEY, PHILLIP J. GEIER, MELVIN L. KALLENBACH, WILLIAM L. KECK, ROBERT E. KOCH, WILLIAM D. POWELL, DONALD A. RAUSCH, BERNARD E. SCHNACKE, DONALD E. STEEDLY, D. W. VAUGHN, and JAMES W. VOGEL,

Defendants.

Civil Action

No. 82 C 4296

JURY DEMANDED

Action under Sherman Anti-Trust Act and Clayton Anti-Trust Act (15 U.S.C. § 1 et seq. and 15 U.S.C. § 15 et seq.), under The Civil Rights Act of 1871 (42 U.S.C. § 1982), and Pendant Jurisdiction—Tortious Interference with Business Relations.

FIRST AMENDED COMPLAINT

JURISDICTION, VENUE, PARTIES

1. This Court has jurisdiction over the subject matter of Counts I through IV of this suit under 28 U.S.C. § 1337(a). This suit is brought under §§ 4 and 16 of the Clayton Act (15 U.S.C. §§ 15, 26) to recover treble damages and plaintiff's cost of suit, including reasonable attorney fees, and to obtain injunctive relief for defendant's continuing violation of §§ 1 and 2 of the Sherman Act (15 U.S.C. §§ 1, 2).

2. This Court has jurisdiction over the subject matter of Count V of this suit under 28 U.S.C. §§ 1331 and 1343 and the Constitution of the United States. Count V is brought to redress the deprivation under color of state statutes, ordinances, regulations, custom or usage of rights, privileges and immunities secured by the Fourteenth Amendment to the United States Constitution, and by the Civil Rights Act of 1871, 42 U.S.C. § 1983 in that defendants have lately adopted an anticompetitive, unfair and unconstitutional so-called "Fair Hearing Plan" under color of the State of Indiana's peer review statute (34 Burns Ind. Stat. Ann. 4-12-6), which plan is designed to exclude plaintiff, DR. MARRESE, from the relevant local surgical market, and thus to deprive him of his constitutional and statutory right to pursue his licensed profession, by expelling him unless he can satisfy a panel selected by one of the conspirators that the charges against him lack any substantial factual basis.

3. Venue is properly laid in the Northern District of Illinois under 28 U.S.C. § 1391 in that Defendant, INTERQUAL, has its principal place of business in this District, conducted its audit with employees and independent contractors doing business in this District, communicated in and from this District with a number of other Defendants and otherwise performed various acts which lead to the recommendation to terminate DR. MARRESE'S clinical privileges at the HOSPITAL.

4. Plaintiff, BONE & JOINT SURGEONS, INC., is an Indiana corporation with its main office in Evansville, Indiana.

5. Plaintiff, R. ANTHONY MARRESE, M.D. hereinafter referred to as "DR. MARRESE") graduated first in his class from Loyola Stritch School of Medicine, and at the same time received a Masters of Science Degree in physiology from the Graduate School of Loyola University. He interned at The John Hopkins Hospital and did his residency in orthopedic surgery at the Northwestern University Group Hospitals. He is a Board-certified orthopedic surgeon residing in Evansville, Indiana, licensed to practice medicine in that state, as well as in the State of Illinois. He practices in all areas of orthopedic surgery and specializes in disorders of the spine as an employee of Plaintiff, BONE & JOINT SURGEONS, INC.

6. Approximately 45% of the patients treated by DR. MARRESE travel from Western Kentucky and Southern Illinois into the State of Indiana; and the vast majority of these patients are treated by DR. MARRESE at DEACONESS HOSPITAL. As part of his regular treatment of these out-of-state patients, DR. MARRESE has regular telephonic and other communications across state lines with these patients, their pharmacists and x-ray technicians. In addition, DR. MARRESE is a team surgeon for an Illinois high school, and in this capacity has occasion to travel into the State of Illinois, treat injured athletes and, when necessary, brings them back to the DEACONESS HOSPITAL for the purpose of providing medical treatment for them. In the regular course of his treatment of both his interstate and in-state patients, Plaintiff, DR. MARRESE, through Plaintiff's Bone and Joint Surgeons Inc. purchases medicine, equipment and related supplies from out-of-state purveyors, derives revenues from the Federal Health Care Program commonly known as Medicare and Medicaid as well as from private out-of-state insurance companies and pays management and accounting fees to various out-of-state consultants. The total amount of said out-of-state purchases, revenues, and fees exceed the summ of $500,000.00.

7. In addition to the medical procedures usually performed by orthopedic surgeons, DR. MARRESE, in the last five years, has performed a large number of complex spinal operations (including radiological, diagnostic and follow-up treatment) most of which he performed by using the operating room facilities of the DEACONESS HOSPITAL. In those situations where the patient had a previous lumbar procedure those operations can only be performed at the DEACONESS HOSPITAL since that HOSPITAL is the only one in Evansville with a "cell saver."

8. The Defendant, INTERQUAL, INC. (hereinafter referred to as "INTERQUAL") is a Delaware corporation with its principal place of business within the State of Illinois. It purports to offer expert inpartial medical audit services to various hospitals and other medical institutions throughout the United States. It falsely purported to perform such an audit of the medical procedures of Plaintiff, DR. MARRESE, as hereinafter described.

9. Defendant, DEACONESS HOSPITAL, (hereinafter referred to as the "HOSPITAL") is a not-for-profit health care facility incorporated in the State of Indiana and located in Evansville, Indiana. Evansville is at the apex of the so-called "tri-state area" where the HOSPITAL regularly serves patients from Southern Indiana, Western Kentucky and Southern Illinois. Approximately 25% of the HOSPITAL'S patients travel from Kentucky and Illinois to the HOSPITAL for the purpose of receiving medical and surgical care from its professional staff.

10. The HOSPITAL'S regular billings with respect to said out-of-state patients are not less than TEN MILLION DOLLARS ($10,000,000.00) per year.

11. The HOSPITAL also purchases medical supplies and equipment in an amount not less than FIVE MILLION DOLLARS ($5,000,000.00) per year from various out-of-state sources.

12. At all times herein concerned, there existed at Defendant HOSPITAL, two committees which undertook dealings with Plaintiff, DR. MARRESE; for purposes of clarity, these committees are herein described as follows:

(a) Special Ad Hoc Committee of the Medical Staff (hereinafter referred to as "SAHC"); and

(b) Executive Committee of the Medical Staff (hereinafter referred to as the "Executive Committee").

13. Defendant, WILLIAM H. ALLEN, M.D. (hereinafter referred to as "DR. ALLEN") is a resident of Evansville, Indiana, is a neurosurgeon on the staff of the HOSPITAL and as such is a competitor of Plaintiff, DR. MARRESE, for surgical spine patients in the Evansville, Indiana, marketing area. Since February, 1978, he has been either a member or chairman of the SAHC.

14. Defendant, BRYANT A. BLOSS, M.D. (hereinafter referred to as "DR. BLOSS") is a resident of Evansville, Indiana, is an orthopedic surgeon on the staff of the HOSPITAL, and as such is a competitor of Plaintiff, DR. MARRESE, for surgical spine and other patients in the Evansville, Indiana marketing area. In addition, since May, 1980, he has been a member of the SAHC.

15. Defendant, THOMAS EVANS, M.D. (hereinafter referred to as "DR. EVANS") is a resident of Henderson, Kentucky, is an orthopedic surgeon on the staff of the HOSPITAL and as such is a competitor of Plaintiff, DR. MARRESE, for surgical spine and other patients from the Evansville, Indiana marketing area. In addition, since August, 1978, he has been a member of the SAHC.

16. Defendant, AHMET K. PERCINEL, M.D. (hereinafter referred to as "DR. PERCINEL") is a resident of Evansville, Indiana, is an orthopedic surgeon on the staff of the HOSPITAL and as such is a competitor of Plaintiff, DR. MARRESE, for surgical spine and other patients from the

Evansville, Indiana, marketing area. In addition, since August 1978, he has been a member of the SAHC.

17. Defendant, PEDRO DOMINQUEZ, M.D., (hereinafter referred to as "DR. DOMINQUEZ") is a resident of Evansville, Indiana, is a neurological surgeon on the staff of the HOSPITAL and as such is a competitor of Plaintiff, DR. MARRESE, for surgical spine patients from the Evansville, Indiana marketing area. In addition, since May, 1980, he has been a member of the SAHC.

18. Defendant, SAM B. BAKER, M.D. (hereinafter referred to as "DR. BAKER") is a resident of Evansville, Indiana, a Director of the HOSPITAL where he was until recently Chief of Radiology and President of the Medical Staff. In addition, at all times herein alleged, he has been a member of the SAHC and the Executive Committee. Furthermore, DR. BAKER attended SAHC meetings of February 1982 and March 22, 1982, and is a competitor of Plaintiff, DR. MARRESE for the delivery of radiological services in the Evansville, Indiana marketing area.

19. Defendant, DAVID A. JOHNSON, hereinafter referred to as "JOHNSON") is Administrator of the HOSPITAL and a member of SAHC and Executive Committee and attended the meetings of those committees in 1982.

20. Defendant, JOHN C. RENDER, (hereinafter referred to as "RENDER"), is a resident of Indianoplis, Indiana, and is the attorney for and a member of the SAHC and the Executive Committee.

21. Defendant, KENNETH NACHTNEBEL, M.D., (hereinafter referred to as "DR. NACHTNEBEL") is a resident of Evansville, Indiana and as of May 1, 1982, was President of the Medical Staff, a Director of the HOSPITAL, and a member of the Executive Committee.

22. Defendants, C. LEROY ANDERSON, DAVID L. BARNING, C. JACK BUSCHKILL, MRS. JEAN G. DREM-

STEDT, GERALD M. FINNEY, PHILLIP J. GEIER, ROBERT L. KOCH, WILLIAM D. POWELL, DONALD A. RAUSCH, BERNARD E. SCHNACKE, D. W. VAUGHN and JAMES W. VOGEL, are all residents of Evansville, Indiana, and are members of the Board of Directors of Defendant HOSPITAL.

23. Defendants, MELVIN L. KALLENBACH and DONALD E. STEEDLY, are residents of Newberg, Indiana, and Defendant, WILLIAM L. KECK, is a resident of Mr. Vernon, Indiana, and are also members of the Board of Directors of the HOSPITAL.

24. All of the Directors named herein have directly assisted and promoted the alleged conspiracy of the other Defendants by declining to take reasonable precautions to prevent the anti-competitive practices hereinafter enumerated.

25. As a result of defendants' continuing conspiracy and other action in violation of the federal antitrust as hereinafter fully described, interstate commerce relative to the providing of orthopedic, neurological spine surgical services at the HOSPITAL and in the HOSPITAL'S marketing area, has been and will continue to be substantially adversely affected in that, among other things, Defendants would perpetuate and reinforce a variety of restrictive, anti-competitive practices in the relevant market. DR. MARRESE is and has been the major opponent of such practices and defendants now seek to exclude him from the relevant market for that reason and because of the serious competition threat that he poses to them.

RELEVANT MARKET

26. The relevant market for purposes of the anti-trust counts of this Complaint is the market for orthopedic and neurological spinal surgical procedures performed in Evansville, Indiana.

COUNT I

1.-26. The allegations of paragraph 1 through 26 are hereby incorporated by reference.

27. Beginning in early 1978 and continuing thereafter to the present, the Defendants have engaged in an unlawful conspiracy to exclude DR. MARRESE from the Evansville, Indiana marketing area by falsely charging that he is unqualified to practice and compete therein.

28. Said conspiracy has consisted of, among other things, a continuing course of action among the individual medical defendants, ALLEN, BLOSS, EVANS, PERCINEL, DOMINQUEZ, BAKER, NACHTNEBEL, and the Defendant HOSPITAL, and its Administrator, Defendant JOHNSON, its attorney, Defendant RENDER and Defendant INTERQUAL, in attributing DR. MARRESE'S success in his medical practice to his willingness to perform large numbers of "inappropriate and unwarranted surgical procedures."

29. Said conspiracy was undertaken not only because of DR. MARRESE'S aforesaid success in attracting a number of patients that greatly exceeded the number attracted to any other orthopedic surgeons on the HOSPITAL'S staff, but also because DR. MARRESE refused to abide by a number of long-entrenced, anti-competitive trade practices within the aforesaid market.

30. One such practice is an apprenticeship system imposed upon all orthopedic surgeons first entering the Evansville, Indiana marketing area, but expecially upon those who enter from outside of the State of Indiana. In order to become a member of the Medical Staff at the HOSPITAL, this system dictates that an orthopedic surgeon first become "apprenticed" to an orthopedic surgeon on the staff of the HOSPITAL and

thereafter remain in his employ for an extended but undefined period of time without becoming a professional challenge to the employer.

31. DR. MARRESE was formerly thus "apprenticed" to Defendant BLOSS, but was discharged as soon as he showed signs of a willingness to compete with him.

32. Upon leaving the employ of DR. BLOSS, DR. MARRESE refused to withdraw as a staff member at the HOSPITAL and refused to become employed by or associated with another member of the medical staff of the HOSPITAL. Instead he went directly into competition with them, thus further offending the anticompetitive local tradition.

33. Another such anti-competitive trade practice is the refusal of orthopedic and neurological surgeons to accept patients who have been treated by other orthopedic surgeons in the market area, without specific approval and referral from those surgeons.

34. DR. MARRESE has also refused to conform to this trade practice and has, in fact, attracted considerable patient business from his competitors at the HOSPITAL in particular and in the relevant market in general.

35. Another such anti-competitive practice is the opposition of staff orthopedic and neurological surgeons and the HOSPITAL to the introduction of advanced, highly sophisticated diagnostic equipment by any orthopedic surgeon in his own office for his own use.

36. DR. MARRESE'S active competition also offended this practice when he made an initial deposit of $10,000.00 for the purchase of a $500,000.00 advanced computerized Tomography Body Scanner (known as "C. T. Scanner") for his exclusive office use which was perceived by defendants to be a serious threat to their own trade practice. This purchase has not been completed as of the date of this Complaint, due to the threatened termination of DR. MARRESE'S staff privileges.

37. The private acquisition of such an advanced diagnostic tool in conjunction with the continuation of his staff privileges, would automatically have placed DR. MARRESE at an even greater competitive advantage over the other members of the orthopedic, neurological and radiological staff of the HOSPITAL, as well as causing substantial loss of revenue to the HOSPITAL.

38. Another such anti-competitive trade practice has been the refusal of all orthopedic surgeons on the HOSPITAL'S staff to treat a patient of DR. MARRESE'S when DR. MARRESE was out of town even when the patient was in critical need of orthopedic services.

39. On information and belief, DR. MARRESE states that he has been attacked for doing "to may backs", and because his patients occupy a relatively large number of beds at the HOSPITAL, thus making it more difficult for Defendants' orthopedic and neurological surgeons to hospitalize their patients. He has also been attacked because of his diagnostic and surgical ability to correct a variety of complex spinal conditions that local competitor surgeons are unable to perform. Still another reason for the attack on DR. MARRESE is that he is in direct competition with local neurological surgeons for the performance of certain spinal procedures.

40. In formulating and effectuating their resulting conspiracy to eliminate plaintiffs as competitors in the relevant market and particularly for patients treated at the HOSPITAL, defendants further specifically agreed and conspired to perform the following acts:

(a) In February, 1978, defendant, ALLEN, a member of the Medical Staff of the HOSPITAL, recommended that an audit be conducted of "back" procedures performed at the HOSPITAL. It had previously been the practice at the HOSPITAL to have audits of this general sort performed by the Medical Audit Committee, and the

Executive Committee initially recommended that this audit be conducted by this Committee, of which DR. MARRESE was a member. However, subsequently, the audit was instead assigned to SAHC, a Committee headed by a urologist, Dr. Rabin. Dr. Rabin Immediately named defendants, ALLEN, EVANS and PERCINEL to that Committee.

(b) Although Plaintiffs are not now aware of the exact numbers involved, there were approximately three times as many lumbar laminectomies as spinal fusions performed at the HOSPITAL during the period in question. Nevertheless, the members of SAHC, knowing full well that DR. MARRESE performed the vast majority of spinal fusions, audited 50 lumbar laminectomies and 40 spinal fusions. Of the 40 spinal fusions audited, 32 were performed by DR. MARRESE and 8 by six other orthopedic surgeons.

(c) All of DR. MARRESE'S lumbar laminectomies were found to have been performed in accordance with the nationwide and areawide quality criteria. Notwithstanding that DR. MARRESE'S spinal fusions also met all nationwide and areawide quality criteria, SAHC, then consisting of defendants, ALLEN, BLOSS, EVANS and PERCINEL, elected to examine those audited cases by the arbitrary and restrictive criteria of what they considered to be "reasonable" grounds for performing such surgery and "reasonable" extents or levels of such surgery. Thus in 24 of DR. MARRESE'S 32 spinal fusions audited, the Committee questioned the appropriateness, but not the results of DR. MARRESE'S surgery.

(d) There was no objective basis for such findings; indeed in various of the cases that were audited, DR. MARRESE undertook the surgery because of continuing severe spinal problems experienced by patients, some of whom had been under the care of other competing

orthopedic and enurological surgeons, but had not had those problems corrected.

(e) During the course of the aforesaid audit, defendants concealed its existence from DR. MARRESE. Subsequently, upon its conclusion and without affording him an opportunity to respond, defendant, ALLEN, the then acting Chairman of the SAHC, officially recommended to the full medical staff that all of DR. MARRESE'S lumbar laminectomies and spinal fusion cases should be monitored, and all his cases which did not have a positive radiological finding should be subjected to a mandatory second opinion.

(f) In making this recommendation to the full medical staff, defendant, ALLEN, violated the provisions of the Indiana Peer Review Statute which provides that any health care provider under investigation be allowed to review all the data collected by the relevant committee and to offer rebuttal data before any outside disclosure or making of recommendations by the Committee.

(g) Following the aforesaid publication and negative recommendations by the SAHC, DR. MARRESE met with defendants, PERCINEL, ALLEN and EVANS on or about January 31, 1980, to discuss 24 of the 32 cases audited which had been criticized. At that meeting, only one case was reviewed and the records in that case themselves disclosed that it met all areawide and nationwide criteria.

(h) This discovery so angered the SAHC that defendant, ALLEN, appointed new members to that Committee including defendants, BLOSS and DOMINQUEZ. The SAHC then sent 8 of the 32 cases to an outside auditor for review. After reviewing these cases, the outside auditor stated that he could form no conclusion about DR. MARRESE, but instead recommended that not only DR. MAR-

RESE'S but all other orthopedic and neurological procedures performed at the HOSPITAL be sent for an outside audit for review by two auditors, one to be selected by DR. MARRESE and one to be selected by the HOSPITAL.

(i) However because of its desire to single out DR. MARRESE for punishment for his departures from the aforesaid anti-competitive practices, the HOSPITAL failed to act upon this recommendation.

41. Thereafter, in August, 1980, a proposal was made to require each staff member at the HOSPITAL to provide two alternate physicians in that member's sub-specialty, to attend a doctor's patients in the event of that doctor's absence. In immediate succession, at the end of the same month, every member of the orthopedic staff either resigned or refused DR. MARRESE'S request to serve as his alternate.

42. At approximately the same time that it became general knowledge that Plaintiffs intended to purchase a C. T. Scanner, the HOSPITAL, at the instigation of, and in conspiratorial combination with the individual members of the medical staff, instructed a member of the SAHC and the Medical Staff Executive Committee, Attorney John Render, a defendant herein, to contact defendant, INTERQUAL, a company engaged in the business of performing medical audits, with the express purpose of conducting a second audit on certain of plaintiff MARRESE'S lumbar laminectomies and spinal fusions, not previously subjected to audit.

43. Defendant, INTERQUAL, conducted an audit of 93 of DR. MARRESE'S procedures, 70 of which were lumbar procedures and 23 of which were cervical procedures.

44. In conducting this audit, defendant, INTERQUAL, reviewed only the facesheets, the history and physical examination, a limited number of x-ray reports, laboratory test results and discharge summaries. When the record reflected the

existence of other materials bearing upon the conclusions that had been drawn, defendant, INTERQUAL, did not request this material. When abnormalities were noted in the body of an x-ray report, INTERQUAL disregarded that information. When additional x-rays and diagnostic tests were performed outside of the hospital and this was reflected in the material in their possession, defendant, INTERQUAL, did not request an opportunity to review that information. Defendant, INTERQUAL, made no attempt to read myleograms, misread myleogram reports, failed to secure other reports suggested "Fourth Generation C. T. scans when such procedures were not technically available during the time period in question, and submitted a report that contained so many clerical and interpretative errors that it reflects a total lack of good faith and malice towards Plaintiffs.

45. Defendants, ALLEN, BLOSS, EVANS, PERCINEL, DOMINQUEZ, BAKER, RENDER, and JOHNSON, as members of the SAHC, have now made the finding of INTERQUAL the basis for their recommendation to the Executive Committee of the medical staff to revoke the clinical privileges of DR. MARRESE at the HOSPITAL. This unquestioned adoption of the INTERQUAL report by the Executive Committee in conjunction with the other conduct enumerated herein exhibits a complete lack of good faith on the part of the Committee members and malice towards the Plaintiffs.

46. On April 28, 1982, the Executive Committee adopted the recommendation of the SAHC but stayed the termination of DR. MARRESE'S clinical privileges pending the hearing called for in the HOSPITAL'S "Fair Hearing Plan."

47. The attempt to exclude DR. MARRESE from staff privileges at the HOSPITAL and from providing medical services to his patients in the Evansville, Indiana marketing area, has been motived by his competitors' malice directed toward his aggressive competitive actions, his treatment of former patients of other staff members without prior referral

from them, his development of a successful independent medical practice, his refusal to remain employed by or associated with other area orthopedic surgeons, his refusal to resigh his staff privileges, and his refusal to abide by various other anti-competitive trade practices at the HOSPITAL.

48. On information and belief, some of those same competitors, the defendant doctors, have likewise conspired to exclude DR. MARRESE from the American Academy of Orthopedic Surgeons, thus further injuring him and impairing his practice.

DAMAGES

49. As a direct and proximate result of defendants' conspiracy, DR. MARRESE has suffered a severe professional stigma accompanied by a loss in patient referrals from other physicians and the nursing staff at the HOSPITAL. This total loss of profits from these sources alone over the past four years has been not less than $1,500,000.00.

50. If Defendants' conspiracy is successful in its ultimate objective of driving DR. MARRESE from the Evansville, Indiana marketing area, he will lose the entire accumulated good will of his present practice, his recognition as an able orthopedic surgeon and in his sub-specialty of spinal surgery, and be unable to practice orthopedic medicine anywhere else in the United States because of the cost of medical malpractice insurance, and because no other hospital could afford the risk of accepting DR. MARRESE on its staff. The damage to DR. MARRESE, therefore, will represent not less than $15,000,000.00 over the estimated remainder of his professional career.

WHEREFORE, Plaintiffs, DR. MARRESE and BONE & JOINT SURGEONS, INC., pray that this Court enter judgment against all of the Defendants and each of them, for three

times the total of the above amounts together wih all costs of this action, including reasonable attorney's fees.

COUNT II

1.-50. The allegations of Paragraphs 1 through 50 are hereby incorporated by reference.

51. The exact amount of DR. MARRESSE'S future damages in the event that the aforesaid conspiracy is fully successful cannot presently be determined. However, his injury will be grave and irreparable. No money damages can ever fully compensate him for this threatened, lifelong professional disgrace.

WHEREFORE, pursuant to § 16 of the Clayton Act (12 U.S.C. § 26) Plaintiffs, DR. MARRESE and BONE & Joint SURGEONS, INC., pray that this Court enter a permanent injunction restraining defendants and each of them from all of the aforesaid continuing anti-trust violations, and that it grant them such other and further relief as it may deem just and proper, together with all costs of this action, including reasonable attorney's fees.

COUNT III

1.-50. The allegations of Paragraphs 1 through 50 of Count II are hereby incorporated by reference.

52. Defendants' acts and conspiracy as above described have constituted an attempt and conspiracy to monopolize the aforesaid market for the delivery of orthopedic and neurological spinal surgical procedures. They have done so by taking, threatening to take, condoning and assisting the taking of exclusionary action against all competitors who are seen as competitively "agressive".

53. More than 40% of all the orthopedic and neurological surgical operations performed in Evansville during each of the past four years were performed at the HOSPITAL by member of its professional staff.

54. The HOSPITAL possesses unique and indispensable facilities for the sorts of complex, specialized operations that comprise the relevant service market as above defined. It is, therefore, a distinct submarket within that market and an "essential" facility to which every competitor must have fair and equal access in order to compete effectively.

55. Moreover, immediately upon the termination of his clinical privileges at defendant HOSPITAL, all other hospitals in the Evansville, Indiana marketing area at which DR. MARRESE is presently affiliated, will also be required to terminate his staff privileges since their malpractice carriers will provide no coverage for DR. MARRESE'S procedures.

56. The intent and natural effect of the aforesaid anticompetitive practices directed against any competitor who, like DR. MARRESE, is seen as "aggressive" in seeking to take professional business from any other competitors is to reduce the overall level of output of the relevant services in the relevant market.

WHEREFORE, pursuant t § 4 of the Clayton Act (15 U.S.C. § 15) Plaintiffs, DR. MARRESE and BONE & JOINT SURGEONS, INC., pray for the same relief sought with respect to Count I.

COUNT IV

1.-51. Plaintiff hereby realleges Paragraphs 1 through 51 of Count II as Paragraphs 1 through 54 of this Count IV.

WHEREFORE, pursuant to Section 16 of the Clayton Act (15 U.S.C. § 26) Plaintiffs, DR. MARRESE and BONE &

JOINT SURGEONS, INC., pray that this Court enter a Permanent Injunction and restraining defendants and each of them from all of the aforesaid continuing antitrust violations, and that it grant them such other and further relief as it may deem just and proper, together with all costs of this action including reasonable attorney's fees.

COUNT V

(CIVIL RIGHTS ACTION)

1.-50. The allegations of Paragraphs 1 through 50 of Count II are hereby incorporated by reference.

51. The professional staff of any hospital in the State of Indiana is authorized, pursuant to 31 Burns Indiana Statute 4-12-6(2) (c) (B) to establish a "Peer Review Committee", which is a committee charged with the responsibility of evaluating the qualifications of professional health care providers at a hospital. DR. MARRESE is a "professional health care provider" within the meaning of said statute.

52. Defendant HOSPITAL attempted to implement the provisions of that statute on June 2, 1980 by adopting a "Fair Hearing Plan", a copy of which is attached hereto as Exhibit "A".

53. The plan adopted calls for two hearings, one being an Evidentiary hearing and one being an Appellate hearing in the event that any adverse action is taken by recommendation of the Medical Staff Executive Committee.

54. To date there has been no evidentiary hearing, but under the Fair Hearing Plan of defendant HOSPITAL, the President of the medical staff, after an adverse recommendation by the Executive Committee of the medical staff, is to appoint a hearing committee consisting of five (5) members of the senior or active medical staff of said hospital and to appoint a chairman of this hearing committee.

55. The President of the medical staff of defendant HOSPITAL is presently defendant NACHTNEBEL, who was a member of the Executive Committee of the medical staff, and voted in accordance with the actions of said Committee.

56. The Fair Hearing Plan adopted by defendant HOSPITAL provides, in part, as follows:

> "... the body whose adverse recommendation or action occasioned the hearing, shall have the initial obligation to present evidence in support thereof; but the practitioner shall thereafter be responsible for supporting his challenge to the adverse recommendation or action by preponderance of the evidence that the grounds therefore lack any substantial factual basis or that such basis or that the conclusions drawn therefrom are either arbitrary, unreasonable or capricious."

57. The "Fair Hearing Plan" adopted by defendant HOSPITAL is violative of plaintiff DR. MARRESE'S right to due process of law in that those judging his medical qualifications are selected by one who participated in the adverse recommendation in the first instance, thereby violating plaintiff's rights to procedural due process of law in violation of the Fourteenth Amendment of the Constitution of the United States.

58. The "Fair Hearing Plan" adopted by defendant HOSPTIAL also denied plaintiff's right to substinative due process of law in that the burden imposed upon him of showing a lack of "any substantial factual basis" for the Executive Committee of the Medical Staff's recommendation or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable or capricious, creates a presumption strongly in favor of the recommendations of the medical staff, and one which creates a strong presumption of guilt in violation of the Fourteenth Amendment of the United States Constitution.

59. In addition to the Constitutional Violations enumberated above, the Fair Hearing Plan adopted by the HOSPITAL does not comply with the Indiana Peer Review Act.

WHEREFORE, Plaintiffs, R. ANTHONY MARRESE and BONE & JOINT SURGEONS, INC., pray:

1. That the Court declare the procedure whereby the President of the Medical Staff of defendant HOSPITAL is authorized to appoint a Hearing Committee, when the President of the Medical Staff has served on the Medical Executive Committee making the adverse recommendation, to be a violation of plaintiffs' constitutional rights and therefore void and of no effect.

2. That this Court declare the action of defendant HOSPITAL, wherein the burden of proof is being placed upon plaintiffs to show by a preponderance of the evidence that the recommendation of the Medical Executive Committee lacked any substantial factual basis, or that such basis or the conclusions drawn therefrom were either arbitrary, unreasonable or capricious, is violative of plaintiffs' constitutional rights, and therefore void and of no effect.

3. That a permanent injunction issue enjoining the President of the Medical Staff of the HOSPITAL from naming a committee to sit in review of the recommendation of the Executive Committee of the Medical Staff.

4. That a Preliminary Injunction issue restraining and enjoining defendant HOSPITAL from proceeding to a hearing on the issues raised by the Medical Executive Committee for so long as the burden of proof remains upon DR. MARRESE to show by a preponderance of the evidence that the grounds for that recommendation lack any substantial factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable or capricious.

5. That plaintiffs be granted a judgment in money damages against defendant HOSPITAL for the loss of income that they may suffer as a result of defendant's unconstitutional action towards them.

6. That plaintiffs, be awarded reasonable attorney's fees and cost of suit to be assessed against defendant HOSPITAL as required by law.

7. That plaintiffs be awarded such other and further equitable and legal relief as may be deemed just under the circumstances.

COUNT VI

PENDENT JURISDICTION—TORTIOUS INTERFERENCE WITH BUSINESS RELATIONS

1.-49. The allegations of Paragraphs 1 through 49 of Count II are hereby incorporated by reference.

50. Beginning at the time of their involvement as hereinbefore alleged, defendants, ALLEN, BLOSS, EVANS, PERCINEL, DOMINQUEZ, BAKER, NACHTNEBEL, JOHNSON, RENDER, INTERQUAL, INC. and the HOSPITAL, with full knowledge that plaintiff MARRESE'S staff privileges at defendant HOSPITAL constituted the foundation for both plaintiffs success in the business of delivering orthopedic, neurological and radiological medical services, did wrongfully and maliciously endeavor to cause plaintiff MARRESE'S staff privileges at the HOSPITAL to be terminated and did by their acts, as above enumerated, attempt to force plaintiff MARRESE to leave the town of Evansvill, Indiana.

51. That all of the acts alleged above were performed by these defendants with the sole design of injuring plaintiffs and destroying their business and not for the purpose of serving any legitimate interest.

52. As a direct and proximate result of defendants' conduct, DR. MARRESE has suffered a severe professional stigma accompanied by a loss in patient referrals from other physicians as well as the nursing staff of the HOSPITAL. This

total loss of profit from these sources alone over the past four years has been no less than $1,500,000.00.

53. If defendants' efforts are successful in their ultimate objective of causing plaintiff MARRESE'S staff privileges at the HOSPITAL to be terminated and in forcing DR. MARRESE to leave the Evansville, Indiana marketing area, he will lose the entire accumulated goodwill of his present practice, his recognition as a competent orthopedic surgeon in all areas of that practice, and particularly in his subspecialty of spinal surgery, and be unable to practice orthopedic medicine anywhere in the United States because of the cost of medical malpractice insurance and because no other hospital could afford the risk of accepting DR. MARRESE on its staff. The damage to DR. MARRESE, therefore, would represent no less than $15,000,000.00 over the estimated remainder of his professional career.

WHEREFORE, plaintiffs, DR. MARRESE and BONE & JOINT SURGEONS, INC., pray that this Court enter judgment against defendants, ALLEN, BLOSS, EVANS, PERCINEL, DOMINQUEZ, BAKER, NACHTNEBEL, JOHNSON, RENDER, INTERQUAL, INC. and HOSPITAL and each of them for $16,500,000.00 together with costs of this action.

COUNT VII

1.-53. The allegations of Paragraphs 1 through 53 of Count VI are hereby incorporated by reference.

54. The exact amount of plaintiffs' future damages in the event that the acts enumberated above performed by defendants are fully successful, cannot presently be determined. However, his injury will be grave and irreparable. No money damages can ever fully compensate him for his threatened termination of his clinical privileges and his lifelong professional disgrace.

WHEREFORE, plaintiffs. DR. MARRESE and BONE & JOINT SURGEONS, INC., pray that this Court enter a Permanent Injunction restraining said defendants and each of them from all of the aforesaid acts and that it grant them such other and further relief as it may deem just and proper, together with all costs of this action.

R. ANTHONY MARRESE, M.D. and
BONE & JOINT SURGEONS, INC.

By: /s/ JOHN J. CASEY
John J. Casey
One of Their Attorneys

JOHN J. CASEY
LANDESMAN & SCHWARTZ
111 W. Washington Street
Suite 1025
Chicago, Illinois 60602
(312) 346-6650

JURY DEMAND

I, John J. Casey, one of the attorneys for plaintiffs, R. ANTHONY MARRESE, M.D. and BONE & JOINT SURGEONS, INC., hereby demand a trial by jury on the issues listed in this Complaint.

/s/ JOHN J. CASEY
John J. Casey

JOHN J. CASEY
LANDSMAN & SCHWARTZ
Attorneys for Plaintiffs
111 W. Washington St.
Suite 1025
Chicago, Illinois 60602
(312) 346-6650

AFFIDAVIT OF SERVICE

STATE OF ILLINOIS
COUNTY OF COOK } SS.:

JOHN J. CASEY, being first duly sworn on oath, deposes and says that he served the foregoing instrument upon:

SEE ATTACHED LIST

by mailing true and correct copies of the same this 26th day of July, 1982 and by depositing the said copies in the United States Mail at 111 W. Washington Street, Chicago, Illinois, 60602, postage prepaid, addressed as above shown.

/s/ JOHN J. CASEY
John J. Casey

SUBSCRIBED and SWORN to before me this 26th day of July, 1982.

/s/ Donna V. Sigma
Notary Public

JOHN J. CASEY
LANDESMAN & SCHWARTZ
111 West Washington Street
Suite 1025
Chicago, Illinois 60602
(312) 346-6650

EXHIBIT NO. A

FAIR HEARING PLAN

INTRODUCTION

It is the intent of the Medical Staff, by the adoption of this Fair Hearing Plan, to provide every practitioner with one evidentiary hearing and with one appellate hearing in the event that any action is taken by the Medical Staff Executive Council (hereafter MEC) or the Board of Directors of the Hospital. It is further the intention of the Medical Staff in adopting the Fair Hearing Plan that the practitioner be granted only one evidentiary hearing and one appellate hearing. It is intended that the provisions of the Plan following shall be initiated upon an adverse action of the MEC or the Board of Directors as the term adverse action is hereinafter defined. With respect to initial appointment, limitation of staff priviliges, revocation of staff privileges, or suspension or revocation of clinical privileges, as hereinafter specified, the MEC shall give the appropriate notice as hereinafter required to the practitioner. If, however, the adverse action is an action of the Board of Directors taken contrary to a favorable recommendation of the MEC, it is intended that the right to a fair hearing shall be enjoyed by an practitioner in the same manner as if such unfavorable or adverse action had been taken initially by the MEC.

ARTICLE I—INITIATION OF HEARING

1.1 RECOMMENDATIONS OR ACTIONS

The following recommendations or actions shall, if deemed adverse pursuant to Section 1.2 of this Plan, entitle the practitioner affected thereby to a hearing:

(a) Denial of initial staff appointment

(b) Denial of reappointment

(c) Suspension of staff membership

(d) Revocation of staff membership

(e) Denial of requested advancement in staff category

(f) A change in staff category not acceptable to the practitioner

(g) Limitation of the right to admit patients

(h) Denial of requested department/service/section affiliation

(i) Denial of requested clinical privileges

(j) Reduction in clinical privileges

(k) Suspension of clinical privileges

(l) Revocation of clinical privileges

(m) Terms of probation

(n) Individual requirement of consultation

1.2 WHEN DEEMED ADVERSE

A recommendation or action listed in Section 1.1 of this Plan shall be deemed adverse only when it has been:

(a) recommended by the medical executive committee (MEC); or

(b) taken by the board contrary to a favorable recommendation by the MEC under circumstances where no right to hearing existed; or

(c) taken by the board on its own initiative without benefits of a prior recommendation by the MEC.

1.3 NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A practitioner against whom an adverse recommendation of action has been taken pursuant to Section 1.2 of this

Plan shall promptly be given special notice by certified mail of such action. Such notice shall:

(a) advise the practitioner of his right to a hearing pursuant to the provisions of the medical staff bylaws and of this Fair Hearing Plan.

(b) specify the number of days following the date of receipt of notice within which a request for a hearing must be submitted.

(c) state that failure to request a hearing within the specified time period shall constitute a waiver of rights to a hearing and to an appellate review on the matter.

(d) state that upon receipt of his hearing request, the practitioner will be notified of the date, time, and place of the hearing and the grounds upon which the adverse action is based.

1.4 REQUEST FOR HEARING

A practitioner shall have ten (10) days following his receipt of a notice pursuant to Section 1.3 to file a written request for a hearing. Such request shall be delivered to the chief executive officer either in person or by certified or registered mail.

1.5 WAIVER BY FAILURE TO REQUEST A HEARING

A practitioner who fails to request a hearing within the time and in the manner specified in Section 1.4 waives any right to such hearing and to any appellate review to which he might otherwise have been entitled. Such waiver in connection with:

(a) An adverse action by the board shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the board.

(b) An adverse recommendation by the MEC shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the board. The board shall consider the committee's recommendation at its next regular meeting following waiver. In its deliberations, the board shall review all the information and material considered by the committee and may consider all other relevant information received from any source. If the board's action on the matter is in accord with the MEC's recommendation, such action shall constitute a final decision of the board. If the board's actions as the effect of changing the MEC's recommendation, the matter shall be submitted to the joint conference committee of the hospital for recommendation. The board's action on the matter following receipt of the joint conference recommendation shall constitute its final decision. The chief executive officer shall promptly send the practitioner special notice informing him of each action taken pursuant to this Section 1.5(b) and shall notify the president of the staff and the chairman of the MEC of each such action.

ARTICLE II—HEARING PREREQUISITES

2.1 NOTICE OF TIME AND PLACE FOR HEARING

Upon receipt of a timely request for hearing, the chief executive officer shall deliver such request to the president of the medical staff or to the board, depending on whose recommendation or action prompted the request for hearing. Within fifteen (15) days after receipt of such request, the president of the staff or the board shall schedule and arrange for a hearing. At least fifteen (15) days prior to the hearing, the chief executive officer shall send the

practitioner special notice of the time, place, and date of the hearing. The hearing date shall be not less than fifteen (15) days nor more than forty-five (45) days from the date of receipt of the request for hearing; provided, however, that a hearing for a practitioner who is under suspension then in effect shall be held as soon as the arrangements for it may reasonably be made, but not later than thirty (30) days from the date of receipt of the request for hearing.

2.2 STATEMENT OF ISSUES

The notice of the hearing required by Section 2.1 shall contain a concise statement of the reasons for the adverse action of the MEC or the board, whichever the case may be. It is intended that the practitioner shall be provided in reasonable detail with the underlying reasons and causes for the adverse action and that the notice of the hearing will contain specific enough reference to such reasons to permit the practitioner to adequately prepare for the evidentiary hearing.

2.3 APPOINTMENT OF HEARING COMMITTEE

2.3-1 BY MEDICAL STAFF

A hearing occasioned by an adverse MEC recommendation pursuant to Section 1.2(a) shall be conducted by a hearing committee appointed by the president of the medical staff and composed of five (5) members of the senior or active medical staff. One of the members so appointed shall be designated as chairman.

2.3-2 BY BOARD

A hearing occasioned by an adverse action of the board pursuant to Section 1.2(b) or (c) shall be conducted by a hearing committee appointed by the

president of the board and composed of five (5) members, all of whom shall be members of the senior or active medical staff of the Hospital. One of the appointees to the committee shall be designated as chairman.

2.3-3 SERVICE ON HEARING COMMITTEE

Whenever possible the members of the hearing committee selected either by the president of the medical staff or the president of the board, as aforesaid, shall be persons who have not participated in initiating or investigating the underlying matter at issue; and wherever possible, such persons shall not have been a member of any body whose adverse recommendation or action occasioned the hearing. It is recognized, however, that it is desirable that persons with particular knowledge of the general subject matter in issue be appointed to the hearing committee; for example, if the matter in issue relates to clinical performance, it is deemed advisable that the hearing committee at least to some extent be comprised of persons knowledgable in the clinical area involved in the particular hearing.

ARTICLE III—HEARING PROCEDURE

3.1 PERSONAL PRESENCE

The personal presence of the practitioner who requested the hearing shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his rights in the same manner and with the same consequence as provided in Section 1.5.

3.2 PRESIDING OFFICER

The chairman of the hearing committee shall preside as the presiding officer at the hearing. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He shall be entitled to determine the order of procedure and the admissability of evidence.

3.3 REPRESENTATION

The practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of the medical staff in good standing or by a member of his local medical society. The MEC or the board, depending on whose recommendation or action prompted the hearing, shall appoint an individual to present the facts in support of its adverse recommendation or action, and to examine witnesses. Representation of either party by an attorney at law shall be governed by the provisions of Section 8.1 of this Plan.

3.4 RIGHTS OF PARTIES

During a hearing, each of the parties shall have the right to:

(a) call and examine witnesses

(b) introduce exhibits

(c) cross-examine any witness on any matter relevant to the issues

(d) question the qualifications of any witness

(e) rebut any evidence

(f) request that the record of the hearing be made by use of a court reporter or an electronic recording unit

The practitioner who requested the hearing may be called and examined as if under cross-examination.

3.5 PROCEDURE AND EVIDENCE

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the hearing record. The presiding officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him and entitled to notarize documents in the state where the hearing is held.

3.6 OFFICIAL NOTICE

In reaching a decision, the hearing committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the state where the hearing is held. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the hearing record. Any party shall be given opportunity, on timely request, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of

such refutation to be determined by the hearing committee. The committee shall also be entitled to consider all other information that can be considered, pursuant to the medical staff bylaws, in connection with applications for appointment or reappointment to the medical staff and for clinical privileges.

3.7 BURDEN OF PROOF

When a hearing relates to Section 1.1(a), (e), (h), or (i), the practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any substantial factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious. Otherwise, the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof; but the practitioner shall thereafter be responsible for supporting his challenge to the adverse recommendation or action by preponderance of the evidence that the grounds therefor lack any substantial factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious.

3.8 RECORD OF HEARING

A record of the hearing shall be kept that is of sufficient accuracy to permit an informed and valid judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The hearing committee may select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings.

3.9 POSTPONENT

Requests for postponement of a hearing shall be granted by the chairman of the hearing committee only upon a

showing of good cause and only if the written request therefor is made as soon as is reasonably practical.

3.10 PRESENCE OF HEARING COMMITTEE MEMBERS AND VOTE

A majority of the hearing committee must be present throughout the hearing and deliberations. If a committee member is absent from substantial any part of the proceedings, he shall not be permitted to participate in the deliberations or the decision.

3.11 RECESSES AND ADJOURNMENT

The hearing committee may recess the hearing and recovene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

ARTICLE IV—HEARING COMMITTEE REPORT AND FURTHER ACTION

4.1 HEARINGS COMMITTEE REPORT

Within fifteen (15) days after final adjournment of the hearing, the hearing committee shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the body whose adverse recommendation or action occasioned the hearing. All findings and recommendations by the hearing

committee shall be supported by reference to the hearing record and the other documentation considered by it.

4.2 ACTION ON HEARING COMMITTEE REPORT

Within thirty (30) days after receipt of the report of the hearing committee, the MEC or the board, as the case may be, shall consider the same and affirm, modify, or reverse its recommendation or action in the matter. It shall transmit the result, together with the hearing record, the report of the hearing committee and all other documentation considered, to the chief executive officer.

4.3 NOTICE AND EFFECT OF RESULT

4.3-1 NOTICE

The chief executive officer shall promptly send a notice by certified mail to the practitioner informing him of the result of the action of the MEC and shall also send such notice to the president of the medical staff, chairman of the MEC, and the board.

4.3-2 EFFECT OF FAVORABLE RESULT

(a) *Adopted by the Board:* If the board's result pursuant to Section 4.2 is favorable to the practitioner, such result shall become the final decision of the board and the matter shall be considered finally closed.

(b) *Adopted by the MEC:* If the MEC's result is favorable to the practitioner, the chief execution officer shall promptly forward it, together with all supporting documentation, to the board for its final action. The board shall take action thereon by adopting or rejecting the MEC's result in whole or in part, or by referring the matter back to the MEC for further reconsideration. Any such referral back shall

state the reasons therefor, set a reasonable time limit within which a subsequent recommendation to the board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the board shall take final action. The chief executive officer shall promptly send the practitioner notice by certified mail informing him of each action taken pursuant to this section 4.3(b). Favorable action shall become the final decision of the board, and the matter shall be considered finally closed. If the board's action is adverse in any of the respects listed in Section 1.1 of this Plan, the special notice shall inform the practitioner of his right to request an appellate review by the board as provided in Section 5.1 of this Plan.

4.3-3 EFFECT OF ADVERSE RESULT

If the result of the MEC or of the board continues to be adverse to the practitioner in any of the respects listed in Section 1.1 of this Plan, the special notice required by Section 4.3-1 shall inform the practitioner of his right to request an appellate review by the board as provided in Section 5.1 of this Plan.

ARTICLE V—INITIATION AND PREREQUISITES OF APPELLATE REVIEW

5.1 REQUEST FOR APPELLATE REVIEW

A practitioner shall have ten (10) days following his receipt of a notice pursuant to Section 4.3-2(b) or 4.3-3 to file a written request for an appellate review. Such request

shall be delivered to the chief executive officer either in person or by certified or registered mail and may include a request for a copy of the report and record of the hearing committee and all other material, favorable or unfavorable, if not previously forwarded, that was considered in making the adverse action or result.

5.2 WAVIER BY FAILURE TO REQUEST APPELLATE REVIEW

A practitioner who fails to request an appellate review within the time and in the manner specified in Section 5.1 above waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 1.5 of this plan.

5.3 NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW

Upon receipt of a timely request for appellate review, the chief executive officer shall deliver such request to the chairman of the board. As soon as practicable, the chairman of the board shall schedule and arrange for an appellate review request; provided, however, that an appellate review for a practitioner who is under a suspension then in effect shall be held as soon as the arrangements for it may reasonably be made, but not later than fifteen (15) days from the date of receipt of the request for review. At least ten (10) days prior to the appellate review, the chief executive officer shall send the practitioner special notice of the time, place, and date of the review. The time for the appellate review may be extended by the appellate review body for good cause and if the written request therefor is made as soon as is reasonably practical.

5.4 APPELLATE REVIEW BODY

The appellate review body shall consist of the joint conference committee of the hospital as it is constituted at

the time of the request for the appellate review. If any of the physician members of the appellate review body shall have been members of the hearing committee, such person shall not be eligible to serve on the appellate review committee. In such case, the president of the medical staff shall designate another member of the medical staff to serve on the appellate review body in place of the individual who was disqualified by reason of serving on the hearing committee. The person so selected by the president of the medical staff shall not have been a member of the hearing committee.

ARTICLE VI—APPELLATE REVIEW PROCEDURE

6.1 NATURE OF PROCEEDINGS

The proceedings by the review body shall be in the nature of an appellate review based upon the record of the hearing before the hearing committee, that committee's report, and all subsequent results and actions thereon. The appellate review body shall also consider the written statements, if any, submitted pursuant to Section 6.2 of this Plan and such other material as may be presented and accepted under Sections 6.4 and 6.5 of this Plan.

6.2 WRITTEN STATEMENTS

The practitioner seeking the review may submit a written statement detailing the findings of fact, conclusions and procedural matters with which he disagrees, and his reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the appellate review body through the chief executive officer at least ten (10) days prior to the scheduled date of the appellate review, except

if such time limit is waived by the appellate body. A written statement in reply may be submitted by the MEC or by the board, and if submitted, the chief executive officer shall provide a copy thereof the practitioner at least five (5) days prior to the schedules date of the appellate review.

6.3 PRESIDING OFFICER

The chairman of the joint conference committee shall be the presiding officer. He shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

6.4 ORAL STATEMENT

The appellate review body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him by any member of the appellate review body.

6.5 CONSIDERATION OF NEW OR ADDITIONAL MATTERS

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only in the discretion of the appellate review body, following an explanation by the part requesting the consideration of such matter or evidence as to why it was not presented earlier.

6.6 POWERS

The appellate review body shall have all the powers granted to the hearing committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

6.7 PRESENCE OF MEMBERS AND VOTE

A majority of the appellate review body must be present throughout the review and deliberations. If a member of the review body is absent from any part of the proceedings, he shall not be permitted to participate in the deliberations or the decision.

6.8 RECESSES AND ADJOURNMENT

The appellate review body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The appellate review body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusions of those deliberations, the appellate review shall be declared finally adjourned.

6.9 RECORD OF THE PROCEEDINGS

A record of the proceedings of the appellate review body shall be taken and kept, which record may be in the form of detailed minutes or by electronic recording.

6.10 ACTION TAKEN

The appellate review body may recommend that the board affirm, modify, or reverse the adverse result or action taken by the MEC or by the board pursuant to Section 4.2 or 4.3-2(b), or, in its discretion, may refer the matter back to the hearing committee for further review and recommendations to be returned to it within a fixed period of time and in accordance with its instructions. Within ten (10) days after receipt of such recommendations after referral, the appellate review body shall make its recommendation to the board as provided in this Section 6.10.

6.11 CONCLUSION

The appellate review shall not be deemed to be concluded until all the procedural steps provided herein have been completed or waived.

ARTICLE VII—FINAL DECISION OF THE BOARD

7.1 BOARD ACTION

Within thirty (30) days after the conclusion of the appellate review, the board shall render its final decision in the matter in writing and shall send notice thereof to the practitioner by registered or certified mail, to the president of the medical staff and to the MEC. The decision of the board shall be immediately effective and final.

ARTICLE VIII—GENERAL PROVISIONS

8.1 ATTORNEYS

If the affected practitioner desires to be represented by an attorney at any hearing or at any appellate review appearance pursuant to Section 6.4, his initial request for the hearing must state his wish to be so represented at either or both such proceedings in the event they are held. The hearing committee and the appellate review body shall determine for the respective proceedings at which they shall preside, whether to permit such representation. If and only if the hearing committee or appellate review body allows the practitioner to be so represented shall the MEC or the board be allowed representation by an attorney. The foregoing shall not be deemed to deprive the practitioner, the MEC or the board of the right to legal counsel in connection with preparation for a hearing or an appellate review.

8.2 NUMBER OF HEARINGS AND REVIEWS

Notwithstanding any other provision of the medical staff by-laws or of this Plan, no practitioner shall be entitled as a right to more than one evidentiary hearing and one appellate review with respect to an adverse recommendation or action.

8.3 RELEASE

By requesting a hearing or appellate review under this Fair Hearing Plan, a practitioner agree to grant immunity with respect to civil prosecution for any testimony, evidence, or other material furnished by an individual either to the initial hearing committee or to the appellate review body. All persons who testify shall be immune from any civil liability for testimony given by them in any proceeding under this Fair Hearing Plan when such proceeding or hearing has been requested by the practitioner.

8.4 WAVIER

If at any time after receipt of special notice of an adverse recommendation, action, or result, a practitioner fails to make a required request or appearance or otherwise fails to comply with this Fair Hearing Plan or to proceed with the matter, he shall be deemed to have consented to such adverse recommendation, action, or result and to have voluntarily waived all rights to which he might otherwise have been entitled under the medical staff by-laws then in effect or under this Fair Hearing Plan with respect to the matter involved.

ARTICLE IX—ADOPTION AND AMENDMENT

9.1 ADOPTION

9.1-1 MEDICAL STAFF

The foregoing Fair Hearing Plan was adopted and recommended to the board by the medical staff of Deaconess Hospital, Inc. and shall be deemed to be an amendment to the constitution and by-laws of the medical staff and to form a part of the constitution and by-laws of the medical staff of Deaconess Hospital, Inc.

Date _____ _____

President of the Medical Staff

9.1-2 BOARD

The foregoing Fair Hearing Plan, as approved by the Medical Staff of Deaconess Hospital Inc., was adopted and approved by resolution of the Board of Directors of Deaconess Hospital, Inc., after considering the recommendation of the medical staff and its appropriate bodies and in accordance with and subject to the hospitals corporate by-laws.

Date _____ _____

Secretary of the Board

9.2 AMENDMENT

This Fair Hearing Plan may be amended or repealed in whole or in part in the same manner as amendments to the constitution and by-laws of the medical staff of the hospital.

*Adopted by the Medical Staff June 20, 1979

UNITED STATES DISTRICT COURT

Northern District of Illinois

Eastern Division

Name of Presiding Judge, Honorable George N. Leighton

Cause No: 82 C 4296 Date: February 28, 1983

Title of Cause: Marrese v. Interqual, et al.

Brief Statement of Motion: Motion to Dismiss

The rules of this court require counsel to furnish the names of all parties entitled to notice of the entry of an order and the names and addresses of their attorney. Please do this immediately below (separate lists may be appended).

Names and Addresses of moving counsel: _____

_____

Representing: _____

_____

Names and Addresses of other counsel entitled to notice and names of parties they represent: _____

_____

Reserve space below for notations by minute clerk

For the reasons stated in the Memorandum filed herewith, the court grants the defendants' motion to dismiss and this case is hereby dismissed in its entirety.—Draft

Leighton, *J.*

IN THE UNITED STATES DISTRICT COURT

Northern District of Illinois

Eastern Division

R. ANTHONY MARRESE, M.D., et al., *Plaintiffs,* *vs.* INTERQUAL, INC., et al., *Defendants.*	No. 82 C 4296 Before the Honorable George N. Leighton United States District Judge

Memorandum

Plaintiffs R. Anthony Marrese, M.D., and Bone & Joint Surgeons, Inc., bring this action under the Sherman Act, 15 U.S.C. §§ 1 *et seq.*, and 42 U.S.C. § 1983. Defendants are Interqual, Inc., Deaconess Hospital, the members of the Special Ad Hoc Committee of the Medical Staff at Deaconess (SAHC), the members of the Executive Committee of the Medical Staff at Deaconess and the members of the hospital's Board of Directors.

Plaintiffs' complaint is in six counts. In Counts I-IV they allege that the defendants' attempts to revoke Dr. Marrese's staff privileges at the Deaconess are part of a conspiracy which has restrained trade in violation of Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2. Count V alleges that the "Fair Hearing Plan" adopted by the hospital violates the Due Process Clause of the Fourteenth Amendment. Count VI raises a state law tort claim for tortious interference with a business relationship. Plaintiffs seek injunctive and compensatory relief.

The cause is before the court on the defendants' motion to dismiss or transfer brought pursuant to Rules 12(b)(2), 12(b)(3) and 12(b)(6), Fed. R. Civ. P., and 28 U.S.C. § 1404. Defendants assert that venue is improper in this district or alternatively, even if it were proper, the case should be

transferred to the Western District of Kentucky or the Southern District of Indiana. They further contend that plaintiffs have failed to allege facts sufficient to establish subject matter jurisdiction under the Sherman Act and have failed to state a claim for which relief can be granted under 42 U.S.C. § 1983. After careful consideration of the parties' submissions, the court concludes that it has no jurisdiction over the Sherman Act claims. It further concludes that plaintiffs have not stated a claim for which relief can be granted under 42 U.S.C. § 1983. Accordingly, it does not address the questions of venue or forum non conveniens.

The alleged facts, which are taken as true for the purposes of the motion, are as follows. Plaintiff Marrese is an employee of plaintiff Bone & Joint Surgeons, Inc., and has clinical privileges at the Deaconess Hospital. He is a Board certified orthopedic surgeon licensed to practice in Illinois and Indiana and specializes in disorders of the spine. In February 1978 an audit was conducted of "back" procedures performed at Deaconess. The results of the audit raised questions in the minds of the members of the SAHC, who conducted the audit, as to the appropriateness of the surgeries performed by Dr. Marrese. Following the audit, the SAHC recommended that certain of Dr. Marrese's cases be monitored. In August of 1980, defendant Interqual was retained to conduct a further audit of Dr. Marrese's cases. Based on the findings of the audit conducted by Interqual, the SAHC recommended to the Executive Committee that Dr. Marrese's clinical privileges be revoked. On April 28, 1982, the Executive Committee adopted the SAHC's recommendation but stayed any action upon it pending a further hearing as required by the hospital's Fair Hearing Plan. Shortly thereafter Dr. Marrese instituted this action.

I. The Sherman Act Claims

Defendants contend that the allegations of the amended complaint are insufficient to establish subject matter jurisdiction

under the Sherman Act. Section 1 of the Act prohibits contracts, combinations or conspiracies which restrain trade or commerce among the States. Section 2 bars attempts to monopolize any part of the trade or commerce between the States. Thus, these sections apply only to interstate transactions or activities. Interstate in this context refers to activities that are actually in interstate commerce as well as to activities that "while wholly local in nature, nevertheless substantially affect interstate commerce." *McClain v. Real Estate Board of New Orleans,* 444 U.S. 232, 241 (1980); *Hospital Building Co. v. Trustees v. Rex Hospital,* 425 U.S. 738, 743 (1976). Plaintiffs have not attempted to meet the "in commerce" test; jurisdiction in this case must then rest on the "affect on commerce test."

In order to meet this jurisdictional test, plaintiffs must allege facts, which if proved, would establish that the defendants' allegedly unlawful conduct would have a substantial effect on interstate commerce. *McClain,* 444 U.S. at 246; *Cardio-Medical Associate v. Crozer-Chester Medical Center,* 536 F.Supp. 1065, 1074 (E.D. Pa. 1982); *Pao v. Holy Redeemer Hospital,* 547 F.Supp. 484, 488-489 (E.D. Pa. 1982). With respect to interstate commerce, plaintiffs have alleged that Dr. Marrese treats people who travel in interstate commerce; that they purchase medicine and related supplies from out-of-state; that Dr. Marrese travels in interstate commerce as part of his business; and that they receive revenues from out-of-state sources such as insurance companies and Medicare.

Plaintiffs have not alleged what effect the defendants attempts to revoke Dr. Marrese's clinical privileges have had on the aspects of interstate commerce alleged. Other than generalized, conclusory allegations plaintiffs have failed to allege any substantial effect on interstate commerce. Viewing the allegations in the aggregate, the court must conclude, as the Tenth Circuit did in a similar case, *Wolf v. Jane Phillips Episcopal-Memorial Medical Center,* 513 F.2d 684, 687 (10th Cir. 1975), that "the facts alleged do not support the proposition that the

restraint upon plaintiff's practice causes more than an insubstantial effect upon interstate commerce." *See Cardio-Medical Association,* 536 F.Supp. at 1082-1083; *Grigg v. Blue Cross and Blue Shield of Michigan,* 1980-2 Trade Cases ¶ 63,500, 76,666 (E.D. Mich. 1980); *Barr v. National Right to Life Committee, Inc.,* No. 79-420-ORL-CIV-Y (M.D. Fla. July 27, 1981). Thus, because the court concludes that defendants' allegedly unlawful actions do not have a substantial effect on interstate commerce, Counts I-IV of the complaint must be dismissed for lack of subject matter jurisdiction.

II. **The Section 1983 Claims**

Section 42 U.S.C. 1983 in pertinent part, provides:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects or causes to be subjected any citizen of the United States or any person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

In order to state a claim under Section 1983, the action complained of must be "state action"; the provisions of the section do not apply to purely private behavior. *Parratt v. Taylor,* 451 U.S. 527, 535 (1981). The only involvement of the state alleged in this case is that the Fair Hearing Plan challenged by plaintiffs were adopted pursuant to an Indiana peer review statute. In this court's view, there is not a "sufficiently close nexus between the State and the challenged action of the unregulated entity that the action of the latter may be fairly treated as that of the State itself." *Jackson v. Metropolitan Edison Co.,* 419 U.S. 345, 351 (1974). Accordingly, the court finds that plaintiffs have not alleged "state action" sufficient to state a claim under Section Sectioni 1983.

III. **State Law Claim**

Plaintiffs' remaining claim is based solely on state law. Under the doctrine of pendent jurisdiction, where the federal

claims have been dismissed before trial, a federal court should not retain jurisdiction over the state law claims. *United Mine Workers v. Gibbs*, 383 U.S. 715, 726 (1966). Having dismissed the federal claims, and finding no circumstances which would justify the continued exercise of jurisdiction over this wholly state law claim, the court hereby dismisses the case in its entirety.

So ordered,

/s/ GEORGE N. LEIGHTON
George N. Leighton,
United States District Judge

Dated: February 28, 1983

IN THE UNITED STATES DISTRICT COURT

For the Northern District of Illinois

Eastern Division

R. ANTHONY MARRESE, M.D. and BONE & JOINT SURGEONS, INC., an Indiana corporation,

Plaintiffs,

vs.

INTERQUAL, INCORPORATED, a Delaware corporation,

and

DEACONESS HOSPITAL, an Indiana not-for-profit corporation,

and

WILLIAM H. ALLEN, M.D., BRYANT A. BLOSS, M.D., THOMAS EVANS, M.D., AHMET K. PERCINEL, M.D., PEDRO DOMINQUEZ, M.D., SAM B. BAKER, M.D., KENNETH NACHTNEBEL, M.D., DAVID A. JOHNSON and JOHN RENDER,

and

C. LE ROY ANDERSON, DAVID L. BARNING, C. JACKSON BUSCHKILL, MRS. JEAN G. DREMSTEDT, GERALD M. FINNEY, PHILLIP J. GEIER, MELVIN L. KALLENBACH, WILLIAM L. KECK, ROBERT L. KOCH, WILLIAM D. POWELL, DONALD A. RAUSCH, BERNARD E. SCHNACKE, DONALD E. STEEDLY, D. W. VAUGHN, and JAMES W. VOGEL,

Defendants.

Civil Action

No. 82 C 4296

JURY DEMANDED

Action under Sherman Anti-Trust Act and Clayton Anti-Trust Act (15 U.S.C. § 1 et seq. and 15 U.S.C., § 15 et seq.), and Pendent Jurisdiction Tortious Interference with Business Relations.

SECOND AMENDED COMPLAINT

JURISDICTION, VENUE, PARTIES

1. This Court has jurisdiction over the subject matter of Counts I through IV of this suit under 28 U.S.C. § 1337(a). This suit is brought under §§ 4 and 16 of the Clayton Act (15 U.S.C. §§ 15, 26) to recover treble damages and Plaintiff's cost of suit, including reasonable attorney fees, and to obtain injunctive relief for defandant's continuing violation of §§ 1 and 2 of the Sherman Act (15 U.S.C. §§ 1, 2).

2. Venue is properly laid in the Northern District of Illinois under 28 U.S.C. § 1391 in that Defendant, INTER-QUAL, has its principal place of business in this District, conducted its audit with employees and independent contractors doing business in this District, communicated in and from this District with a number of other Defendants and otherwise performed various acts which lead to the recommendation to terminate DR. MARRESE'S clinical privileges at the DEACONESS HOSPITAL (hereinafter reffered to as the "HOSPITAL").

3. Plaintiff, BONE & JOINT SURGEONS, INC., is an Indiana corporation with its main office in Evansville, Indiana.

4. Plaintiff, R. ANTHONY MARRESE, M.D. (hereinafter referred to as "DR. MARRESE") graduated first in his class from Loyola Stritch School of Medicine, and at the same time received a Masters of Science Degree in physiology from the Graduate School of Loyola University. He interned at The Johns Hopkins Hospital and did his residency in orthopedic surgery at the Northwestern University Group Hospitals. He is a Board certified orthopedic surgeon, residing in Evansville, Indiana, licensed to practice medicine in that state, as well as in the State of Illinois. He practices in all areas of orthopedic surgery and specializes in disorders of the spine as an employee of Plaintiff, BONE & JOINT SURGEONS, INC.

5. Approximately 300 patients per year travel from Western Kentucky and Southern Illinois into the State of Indiana for treatment by DR. MARRESE. Each patient is seen by DR. MARRESE on six separate occasions for a total of approximately 1,800 visits per year by out-of-state patients into the State of Indiana for the purpose of receiving medical treatment from DR. MARRESE. These patients are billed approximately $1,000,000.00 per year by DR. MARRESE andapproximately $10,000,000.00 by the HOSPITAL. As part of his regular telephonic and other communications accross the state lines with these patients and their out-of-state pharmacists, x-ray technicians and physical rehabilitation personnel. The vase majority of these patients are treated by DR. MARRESE at least once at the HOSPITAL and a large percentage of these cases involve complex spinal surgery. If DR. MARRESE'S privileges at the HOSPITAL are terminated, these patients will not cross state lines in the State of Indiana for their medical treatment for they come to DR. MARRESE because of his superior expertise in spinal diagnosis and treatment. The billing above referred to will, therefore, cease because DR. MARRESE'S practice is a hospital-based practice and he will be unable to continue the practice of medicine.

6. In the regular course of his treatment of both his interstate and intrastate patients, DR. MARRESE, through BONE & JOINT SURGEONS, INC., purchased medicine, equipment and related supplies from out-of-state purveyors. These purchases from out-of-state purveyors represented approximately $100,000.00 per year. If DR. MARRESE'S privileges at the HOSPITAL are terminated, DR. MARRESE'S medical practice will cease because it is primarily a hospital-based practice and these purchases will no longer be made.

7. In fact, at or about the time that Defendant, DEACONESS HOSPITAL, was taking the action hereinafter alleged, DR. MARRESE had entered into an agreement to

purchase a computerized tomography body scanner at a cost of approximately $500,000.00 from a firm located in the State of New Jersey, with financing to be obtained from a St. Louis, Missouri firm. Subsequent to that agreement being made a $7,844.50 down payment was made on this equipment. In the course of making arrangements for the purchase of this scanner DR. MARRESE entered into an agreement to have the scans of x-rays read by a national expert in the field of computerized tomagraphy scanning, a physician with offices in the State of North Carolina. As a result of the action hereinafter alleged, it was necessary for DR. MARRESE to cancel the agreement for the purchase of the scanner, cancel the arrangements for financing and cancel the arrangements for the reading of the x-rays by the out-of-state physician. The reading of the x-rays alone would have generated income to the reading physician of approximately $25,000.00 per year, which payments are not being made due to the action taken by the HOSPITAL as hereinafter alleged.

8. DR. MARRESE is a team physician for an Illinois high school and in this capacity has occasion to travel into the State of Illinois, treat injured athletes and, when necessary, bring these athletes back to the DEACONESS HOSPITAL for the purpose of providing medical treatment for them. If DR. MARRESE'S privileges at the HOSPITAL are terminated, these patients, too, will not cross state lines into the State of Indiana for medical treatment.

9. In the regular course of his interstate and intrastate medical practice DR. MARRESE, through Plaintiff, BONE & JOINT SURGEONS, INC., derives substantial revenue from the Federal health care program, commonly known as Medicare and Medicaid, as well as from private out-of-state insurance companies. In addition, BONE & JOINT SURGEONS, INC. pays management and accounting fees to various out-of-state consultants. The total amount of revenues from out-of-state private and public insurance carriers exceeds

$1,000,000.00 per year and fees paid to out-of-state accountants, management consultants, computer services and pension plan investments exceed $100,000.00. If DR MARRESE'S privileges at the DEACONESS HOSPITAL are, in fact terminated, these payments will likewise terminate.

10. DR. MARRESE admits more patients to the HOSPITAL surgical department than any other physician in the department and is the only physician at the HOSPITAL to present a scientific exhibit to the staff of the HOSPITAL and the only physician at the HOSPITAL to exhibit original work on the diagnosis and treatment of spinal disorders at the national conventions of the American Academy of Orthopaedic Surgeons, the North American Society of Radiologists and the American Society of Neurological Surgeons. In the last five years DR MARRESE has performed more complex spinal fusion operations than any other surgeon in the Evansville, Indiana marketing area and if DR. MARRESE'S privileges at the HOSPITAL are, in fact, terminated, both intrastate and interstate patients presently receiving medical care from DR. MARRESE will no longer have that care available to them in this marketing area.

11. Defendant, DEACONESS HOSPITAL, is a 650 bed not-for-profit health care facility incorporated in the State of Indiana, is the largest hospital in the Evansville, Indiana marketing area and is Evansville's third largest employer. Evansville is at the apex of the so-called "tri-state area" where the HOSPITAL regularly serves patients from Southern Indiana, Western Kentucky and Southern Illinois. Approximately 25% of the HOSPITAL'S patients travel from Kentucky and Illinois to the HOSPITAL for the purpose of receiving medical and surgical care from its professional staff.

12. The HOSPITAL'S regular billings with respect to said out-of-state patients exceed TWENTY-FIVE MILLION DOLLARS ($25,000,000.00) per year.

13. The HOSPITAL also purchsaes medical supplies and equipment in an amount not less than TWENTY MILLION DOLLARS ($20,000,000.00) per year from various out-of-state purveyors.

14. The conspiracy hereinafter alleged to terminate DR. MARRESE'S practice at the HOSPITAL and to drive him from any practice in the relevant market was a necessary and intended part of the larger conspiracy hereinafter alleged to suppress quality competition, and in particular the quality competition throughout that market as alleged in Paragraphs 34, 37 and 39 of this Second Amended Complaint.

15. At all times herein concerned, there existed at Defendant HOSPITAL, two committees which undertook dealings with Plaintiff, DR. MARRESE. For purposes of clarity, these committees are herein as follows:

(a) Special Ad Hoc Committee of the Medical Staff (hereinafter referred to as "SAHC"); and

(b) Executive Committee of the Medical Staff (hereinafter referred to as the "Executive Committee").

16. Defendant, WILLIAM H. ALLEN, M.D. (hereinafter referred to as "DR. ALLEN") is a resident of Evansville, Indiana, is a neurosurgeon on the staff of the HOSPITAL and, as such, is a competitor of Plaintiff, DR. MARRESE, for surgical spine patients in the Evansville, Indiana marketing area. Since February, 1978 he has been either a member or chairman of the SAHC.

17. Defendant, BRYANT A. BLOSS, M.D. (hereinafter referred to as "DR. BLOSS") is a resident of Evansville, Indiana, is an orthopedic surgeon on the staff of the HOSPITAL, and as such is a competitor of Plaintiff, DR. MARRESE, for surgical spine and other patients in the Evansville, Indiana marketing area. In addition, since May, 1980, he has been a member of the SAHC.

18. Defendant, THOMAS EVANS, M.D. (hereinafter referred to as "DR. EVANS") is a resident of Henderson, Kentucky, is an orthopedic surgeon on the staff of the HOSPITAL and as such is a competitor of Plaintiff, DR. MARRESE, for surgical spine and other patients from the Evansville, Indiana marketing area. In addition, since August, 1978 he has been a member of the SAHC.

19. Defendant, AHMET K. PERCINEL, M.D. (hereinafter referred to as "DR. PERCINEL") is a resident of Evansville, Indiana, is an orthopedic surgeon on the staff of the HOSPITAL and as such is a competitor of Plaintiff, DR. MARRESE, for surgical spine and other patients from the Evansville, Indiana marketing area. In addition, since August 1978 he has been a member of the SAHC.

20. Defendant, PEDRO DOMINQUEZ, M.D. (hereinafter referred to as "DR. DOMINQUEZ") is a resident of Evansville, Indiana, is a neurological surgeon on the staff of the HOSPITAL and as such is a competitor of Plaintiff, DR. MARRESE, for surgical spine patients from the Evansville, Indiana marketing area. In addition, since May, 1980, he has been a member of the SAHC.

21. Defendant, SAM B. BAKER, M.D. (hereinafter referred to as "DR. BAKER") is a resident of Evansville, Indiana, a Director of the HOSPITAL, where he was until recently Chief of Radiology and President of the Medical Staff. In addition, at all times herein alleged, he has been a member of the SAHC and the Executive Committee. Furthermore, DR. BAKER attended SAHC meetings of February, 1982 and March 22, 1982 and is a competitor of Plaintiff, DR. MARRESE, for the delivery of radiological services in the Evansville, Indiana marketing area.

22. Defendant, DAVID A. JOHNSON, (hereinafter referred to as "JOHNSON") is Administrator of the HOSPITAL and a member of SAHC and the Executive Committee and attended the meetings of those committees in 1982.

23. Defendant, JOHN C. RENDER (hereinafter referred to as "RENDER") is a resident of Indianapolis, Indiana, and is

the attorney for and a member of SAHC and the Executive Committee. In performing the acts hereinafter alleged he acted beyond his role as attorney for the committee and as an independent conspirator to not only deny DR. MARRESE'S privileges at the HOSPITAL, but, also, to impair DR. MARRESE'S ability to conduct medical research. This conduct consisted of retaining Defendant, INTERQUAL, to perform a false and malicious audit of some of DR. MARRESE'S back surgery and by funnelling to INTERQUAL hospital records and information which were either false and/or inadequate in order for Defendant, INTERQUAL, to make a judgment as to the appropriateness of DR. MARRESE'S surgical procedures.

24. In addition, he falsely testified before an Indiana legislative committee concerning the use of a certain drug which DR. MARRESE had proposed to use for research purposes at the HOSPITAL. As a result of this testimony, the use of this drug by DR. MARRESE or any Indiana physician was not permitted, thereby denying DR. MARRESE an opportunity to further enhance his reputation in the medical community and amongst patients in the Evansville, Indiana marketing area.

25. Defendant, KENNETH NACHTNEBEL, M.D. (hereinafter referred to as "DR. NACHTNEBEL") is a resident of Evansville, Indiana and as of May 1, 1982 was President of the Medical Staff, a Director of the HOSPITAL and a member of the Executive Committee.

26. Defendants, C. LEROY ANDERSON, DAVIL L. BARNING, C. JACK BUSCHKILL, MRS. JEAN G. DREMSTEDT, GERALD M. FINNEY, PHILIP J. GEIER, ROBERT L. KOCH, WILLIAM D. POWELL, DONALD A. RAUSCH, BERNARD E. SCHNACKE, D.W. VAUGHN and JAMES W. VOGEL, are all residents of Evansville, Indiana and are members of the Board of Directors of Defendant, HOSPITAL.

27. Defendants, MELVIN L. KALLENBACH and DONALD E. STEEDLY, are residents of Newburg, Indiana and

Defendant, WILLIAM L. KECK, is a resident of Mt. Vernon, Indiana and are also members of the Board of Directors of the HOSPITAL.

28. All of the Directors named herein have directly assisted and promoted the alleged conspiracy of the other Defendants by declining to take reasonable precautions to prevent the anti-competitive practices hereinafter enumerated.

29. As a result of Defendants' continuing conspiracy and other action in violation of the federal antitrust, as hereinafter fully described, interstate commerce relative to the providing of orthopedic, neurological spine surgical services at the HOSPITAL and in the HOSPITAL'S marketing area has been and will continue to be substantially adversely affected in that, among other things, Defendants would perpetuate and reinforce a variety of restrictive, anti-competitive practices in the relevant market. DR. MARRESE is and has been the major opponent of such practices and Defendants now seek to exclude him from the relevant market for that reason and because of the serious competition threat that he poses to them.

RELEVANT MARKET

30. The relevant market for purposes of the antitrust counts of this Complaint is the market for orthopedic and neurological spinal surgical procedures performed in Evansville, Indiana.

COUNT I

1.-30. The allegations of paragraphs 1 through 30 are hereby incorporated by reference.

31. Beginning in early 1978 and continuing thereafter to the present, the Defendants have engaged in an unlawful conspiracy to exclude DR. MARRESE from the Evansville,

Indiana marketing area by falsely charging that he is unqualified to practice and compete therein.

32. Said conspiracy has consisted of, among other things, a continuing course of action among the individual medical defendants, ALLEN, BLOSS, EVANS, PERCINEL, DOMINQUEZ, BAKER, NACHTNEBEL, and the Defendant HOSPITAL, and its Administrator, Defendant JOHNSON and Defendants RENDER and INTERQUAL in falsely accusing DR. MARRESE of performing large numbers of inappropriate and unwarranted surgical procedures when, in fact, his success is due to the screening of both interstate and intrastate patients and the knowledge and expertise DR. MARRESE has in the area of spinal diagnosis and treatment.

33. Said conspiracy was undertaken not only because of DR. MARRESE'S aforesaid success in attracting a number of patients that greatly exceeded the number attracted to any other orthopedic surgeons on the HOSPITAL'S staff, but, also, because DR. MARRESE refused to abide by a number of long-entrenched, anti-competitive trade practices within the aforesaid market.

34. One such practice is an apprenticeship system imposed upon all orthopedic surgeons first entering the Evansville, Indiana marketing area, but especially upon those who enter from outside the State of Indiana. In order to become a member of the Medical Staff at the HOSPITAL, this system dictates than an orthopedic surgeon first become "apprenticed" to an orthopedic surgeon on the staff of the HOSPITAL and thereafter remain in his employ for an extended but undefined period of time without becoming a professional challenge to the employer.

35. DR. MARRESE was formerly thus "apprenticed" to Defendant BLOSS, but was discharged as soon as he showed signs of a willingness to compete with him.

36. Upon leaving the employ of DR. BLOSS, DR. MARRESE refused to withdraw as a staff member at the HOSPITAL and refused to become employed by or associated with another member of the medical staff of the Hospital. Instead, he went directly into competition with them, thus further offending the anti-competitive local tradition.

37. Another such anti-competitive trade practice is the refusal of orthopedic and neurological surgeons to accept patients who have been treated by other orthopedic surgeons in the market area, without specific approval and referral from those surgeons.

38. DR. MARRESE has also refused to conform to this trade practice and has, in fact, attracted considerable patient business from his competitors at the Hospital in particular and in the relevant market in general.

39. Another such anti-competitive practice is the opposition of staff orthopedic and neurological surgeons and the HOSPITAL to the introduction of advanced, highly sophisticated diagnostic equipment by any orthopedic surgeon in his office for his own use.

40. DR. MARRESE'S active competition also offended this practice when he made an initial deposit of $7,844.50 for the purchase of a $500,000.00 advanced computerized Tomography Body Scanner (known as "C. T. Scanner") from an out-of-state firm for his exclusive office use, which was perceived by Defendants to be a serious threat to their own trade practice. This purchase has not been completed as of the date of this Second Amended Compiaint due to the threatened termination of DR. MARRESE'S staff privileges.

41. The private acquisition of such an advanced diagnostic tool in conjunction with the continuation of his staff privileges would automatically have placed DR. MARRESE at an even greater competitive advantage over the other members of the

orthopedic, neurological and radiological staff of the HOSPITAL, as well as causing substantial loss of revenue to the HOSPITAL.

42. Another such anti-competitive trade practice has been the refusal of all orthopedic surgeons on the HOSPITAL'S staff to treat a patient of DR. MARRESE'S when DR. MARRESE was out of town even when the patient was in critical need of orthopedic services.

43. On information and belief, DR. MARRESE states that he has been attached for doing "to many backs" and because his patients occupy a relatively large number of beds at the HOSPITAL, thus making it more difficult for Defendants' orthopedic and neurological surgeons to hospitalize their patients. He has also been attacked because of his diagnostic and surgical ability to correct a variety of complex spinal conditions that local competitor surgeons are unable to perform. Still another reason for the attack on DR. MARRESE is that he is in direct competition with local neurological surgeons for the performance of certain spinal procedures.

44. In formulating and effectuating their resulting conspiracy to eliminate plaintiffs as competitors in the relevant market and particularly for patients treated at the HOSPITAL, Defendants further specifically agreed and conspired to perform the following acts:

(a) In February, 1978, Defendant, ALLEN, a member of the Medical Staff of the HOSPITAL, recommended that an audit be conducted of "back" procedures performed at the HOSPITAL. It had previously been the practice at the HOSPITAL to have audits of this general sort performed by the Medical Audit Committee, and the Executive Committee initially recommended that this audit be conducted by that Committee, of which DR. MARRESE was a member. However, subsequently, the audit was instead assigned to SAHC, a Committee headed by a

urologist, Dr. Rabin. Dr. Rabin immediately named Defendants, ALLEN, EVANS and PERCINEL to that Committee.

(b) Althought Plaintiffs are not now aware of the exact numbers involved, there were approximately three times as many lumbar laminectomies as spinal fusions performed at the HOSPITAL during the period in question. Nevertheless, the members of SAHC, knowing full well that DR. MARRESE performed the vast majority of spinal fusions, audited 50 lumbar laminectomies and 40 spinal fusions. Of the 40 spinal fusions audited, 32 were performed by DR. MARRESE and eight by six other orthopedic surgeons.

(c) All of DR. MARRESE'S lumbar laminectomies were found to have been performed in accordance with the nationwide and areawide quality criteria. Notwithstanding that DR. MARRESE'S spinal fusions also met all nationwide and areawide quality criteria, SAHC, then consisting of defendants, ALLEN, BLOSS, EVANS and PERCINEL, elected to examine those audited cases by the arbitrary and restrictive criteria of what they considered to be "reasonable" grounds for performing such surgery. Thus, in 24 of DR. MARRESE'S 32 spinal fusions audited, the Committee questioned the appropriateness, but not the results of DR. MARRESE'S surgery.

(d) There was no objective basis for such findings; indeed in various of the cases that were audited, DR. MARRESE undertook the surgery because of continuing severe spinal problems experienced by patients, some of whom had been under the care of other competing orthopedic and neurological surgeons, but had not had those problems corrected.

(e) During the course of the aforesaid audit, defendants concealed its existence from DR. MARRESE. Subse-

quently, upon its conclusion and without affording him an opportunity to respond, defendant, ALLEN, the then Acting Chairman of the SAHC, officially recommended to the full medical staff that all of DR. MARRESE'S lumbar laminectomies and spinal fusion cases should be monitored, and all his cases which did not have a positive radiological finding should be subjected to a mandatory second opinion.

(f) In making this recommendation to the full medical staff, defendant, ALLEN, violated the provisions of the Indiana Peer Review Statute which provides that any health care provider under investigation be allowed to review all the date collected by the relevant committee and to offer rebuttal data before any outside disclosure or making of recommendations by the Committee.

(g) Following the aforesaid publication and negative recommendations by the SAHC, DR. MARRESE met with defendants, PERCINEL, ALLEN and EVANS on or about January 31, 1980, to discuss 24 of the 32 cases audited which had been criticized. At that meeting, only one case was reviewed and the records in that case themselves disclosed that it met all areawide and nationwide criteria.

(h) This discovery so angered the SAHC that defendant, ALLEN, appointed new members to that Committee including defendants, BLOSS and DOMINQUEZ. The SAHC then sent 8 of the 32 cases to an outside auditor for review. After reviewing these cases, the outside auditor stated that he could form no conclusion about DR. MARRESE but, instead, recommended that not only DR. MARRESE'S but all other orthopedic and neurological procedures performed at the HOSPITAL be sent for an outside audit for review by two auditors, one to be selected by DR. MARRESE and one to be selected by the HOSPITAL.

(i) However, because of its desire to single out DR. MARRESE for punishment for his departures from the aforesaid anti-competitive practices, the HOSPITAL failed to act upon this recommendation.

45. Thereafter, in August, 1980, a proposal was made to require each staff member at the HOSPITAL to provide two alternate physicians in that member's sub-specialty, to attend a doctor's patients in the event of that doctor's absence. In immediate succession, at the end of the same month, every member of the orthopedic staff either resigned or refused DR. MARRESE'S request to serve as his alternate.

46. At approximately the same time that it became general knowledge that Plaintiffs intended to purchase a scanner, the HOSPITAL, at the instigation of, and in conspiratorial combination with the individual members of the medical staff, instructed a member of the SAHC and the Medical Staff Executive Committee, JOHN RENDER, a defendant herein, to contact defendant, INTERQUAL, a company engaged in the business of performing medical audits, with the express purpose of conducting a second audit on certain of plaintiff MARRESE'S lumbar laminectomies and spinal fusions, not previously subjected to audit.

47. Defendant, INTERQUAL, conducted an audit of 93 of DR. MARRESE'S procedures, 70 of which were lumbar procedures and 23 of which were cervical procedures.

48. In conducting this audit, defendant, INTERQUAL, reviewed only the facesheets, the history and physical examination, a limited number of x-ray reports, laboratory test results and discharge summaries. When the record reflected the existence of other materials bearing upon the conclusions that had been drawn, defendant, INTERQUAL, did not request this material. When abnormalities were noted in the body of an x-ray report, INTERQUAL disregarded that information. When additional x-rays and diagnostic tests were performed

outside of the hospital and this was reflected in the material in their possession, defendant, INTERQUAL, did not request an opportunity to review that information. Defendant, INTERQUAL, made no attempt to read myleograms, misread myleogram reports, failed to secure other reports, suggested "Fourth Generation C. T. scans" when such procedures were not technically available during the time period in question, and submitted a report that contained so many clerical and interpretative errors that it relects a total lack of good faith and malice towards Plaintiffs.

49. Defendants, ALLEN, BLOSS, EVANS, PERCINEL, DOMINQUEZ, BAKER, RENDER, and JOHNSON, as members of the SAHC, have now made the finding of INTERQUAL the basis for their recommendation to the Executive Committee of the medical staff to revoke the clinical privileges of DR. MARRESE at the HOSPITAL. This unquestioned adoption of the INTERQUAL report by the Executive Committee in conjunction with the other conduct enumerated herein exhibits a complete lack of good faith on the part of the Committee members and malice towards the Plaintiffs.

50. On April 28, 1982, the Executive Committee adopted the recommendation of the SAHC but stayed the termination of DR. MARRESE'S clinical privileges pending the hearing called for in the HOSPITAL'S "Fair Hearing Plan."

51. The attempt to exclude DR. MARRESE from staff privileges at the HOSPITAL and from providing medical services to his patients in the Evansville, Indiana marketing area, has been motived by his competitors' malice directed toward his aggressive competitive actions, his treatment of former patients of other staff members without prior referral from them, his development of a successful independent medical practice, his refusal to remain employed by or associated with other area orthopedic surgeons, his refusal to resign his staff privileges, and his refusal to abide by various other anticompetitive trade practices at the HOSPITAL.

52. On information and belief, some of those same competitors the defendant doctors, have likewise conspired to exclude DR. MARRESE from the American Academy of Orthopedic Surgeons, thus further injuring him and impairing his practice.

DAMAGES

53. As a direct and proximate result of defendants' conspiracy, DR. MARRESE has suffered a severe professional stigma accompanied by a loss in patient referrals from other physicians and the nursing staff at the HOSPITAL. This total loss of profits from these sources alone over the past four years has been not less that $1,500,000.

54. If Defendants' conspiracy is successful in its ultimate objective of driving DR. MARRESE from the Evansville, Indiana marketing area, he will lose the entire accumulated goodwill of his present practice, his recognition as an able orthopedic surgeon and in his subspecialty of spinal surgery, and be unable to practice orthopedic medicine anywhere else in the United States because of the cost of medical malpractice insurance, and because no other hospital could afford the risk of accepting DR. MARRESE on its staff. The damage to DR. MARRESE, therefore, will represent not less than $15,000,000.00 over the estimated remainder of his professional career.

WHEREFORE, Plaintiffs, DR. MARRESE and BONE & JOINT SURGEONS, INC., pray that this Court enter a judgment against all of the Defendants and each of them, for three times the total of the above amounts together with all costs of this action, including reasonable attorney's fees.

COUNT II

1.-53. The allegations of Paragraphs 1 through 53 are hereby incorporated by reference.

54. The exact amount of DR. MARRESE'S future damages in the event that the aforesaid conspiracy is fully successful cannot presently be determined. However, his injury will be grave and irreparable. No money damages can ever fully compensate him for this threatened, lifelong professional disgrace.

WHEREFORE, pursuant to § 16 of the Clayton Act (12 U.S.C. § 26) Plaintiffs, DR. MARRESE and BONE & JOINT SURGEONS, INC., pray that this Court enter a permanent injunction restraining defendants and each of them from all of the aforesaid continuing anti-trust violations, and that it grant them such other and further relief as it may deem just and proper, together with all costs of this action, including reasonable attorney's fees.

COUNT III

1.-53. The allegations of Paragraphs 1 through 53 of Count II are hereby incorporated by reference.

54. Defendants' acts and conspiracy as above described have constituted an attempt and conspiracy to monopolize the aforesaid market for the delivery of orthopedic and neurological spinal surgical procedures. They have done so by taking, threatening to take, condoning and assisting the taking of exclusionary action against all competitors who are seen as competitively "aggressive".

55. More than 40% of all the orthopedic and neurological surgical operations performed in Evansville during each of the

past four years were performed at the HOSPITAL by members of its professional staff.

56. The HOSPITAL possesses unique and indispensable facilities for the sorts of complex, specialized operations that comprise the relevant service market as above defined. It is, therefore, a distinct submarket within that market and an "essential" facility to which every competitor must have fair and equal access in order to compete effectively.

57. Moreover, immediately upon the termination of his clinical privileges at defendant HOSPITAL, all other hospitals in the Evansville, Indiana marketing area at which DR. MARRESE is presently affiliated, will also be required to terminate his staff privileges since their malpractice carriers will provide no coverage for DR. MARRESE'S procedures.

58. The intent and natural effect of the aforesaid anticompetitive practices directed against any competitor who, like DR. MARRESE, is seen as "aggressive" in seeking to take professional business from any other competitors is to reduce the overall level of output of the relevant services in the relevant market.

WHEREFORE, pursuant to § 4 of the Clayton Act (15 U.S.C. § 15) Plaintiffs, DR. MARRESE and BONE & JOINT SURGEONS, INC., pray for the same relief sought with respect to Count I.

COUNT IV

1.-54. Plaintiff hereby realleges Paragraphs 1 through 54 of Count II as Paragraphs 1 through 54 of this Count IV.

WHEREFORE, pursuant to § 16 of the Clayton Act (15 U.S.C. § 26) Plaintiffs, DR. MARRESE and BONE & JOINT SURGEONS, INC., pray that this Court enter a Permanent Injunction and restraining defendants and each of them from all of the aforesaid continuing antitrust violations, and that it

grant them such other and further relief as it may deem just and proper, together with all costs of this action including reasonable attorney's fees.

COUNT V

PENDENT JURISDICTION—TORTIOUS INTERFERENCE WITH BUSINESS RELATIONS

1.-52. The allegations of Paragraphs 1 through 52 of Count II are hereby incorporated by reference.

53. Beginning at the time of their involvement as hereinbefore alleged, defendants, ALLEN, BLOSS, EVANS, PERCINEL, DOMINQUEZ, BAKER, NACHTNEBEL, JOHNSON, RENDER, INTERQUAL, INC. and the HOSPITAL, with full knowledge that plaintiff MARRESE'S staff privileges at defendant HOSPITAL constituted the foundation for both plaintiffs success in the business of delivering orthopedic, neurological and radiological medical services, did wrongfully and maliciously endeavor to cause plaintiff MARRESE'S staff privileges at the HOSPITAL to be terminated and did by their acts, as above enumerated, attempt to force plaintiff MARRESE to leave the town of Evansville, Indiana.

54. That all of the acts alleged above were performed by these defendants with the sole design of injuring plaintiffs and destroying their business and not for the purpose of serving any legitimate interest.

55. As a direct and proximate result of defendants' conduct, DR. MARRESE has suffered a severe professional stigma accompanied by a loss in patient referrals from other physicians as well as the nursing staff of the HOSPITAL. This total loss of profit from these sources alone over the past four years has been no less than $1,500,000.00.

56. If defendants' efforts are successful in their ultimate objective of causing plaintiff MARRESE'S staff privileges at the

HOSPITAL to be terminated and in forcing DR. MARRESE to leave the Evansville, Indiana marketing area, he will lose the entire accumulated goodwill of his present practice, his recognition as a competent orthopedic surgeon in all areas of that practice, and particularly in his sub-specialty of spinal surgery, and be unable to practice orthopedic medicine anywhere in the United States because of the cost of medical malpractice insurance and because no other hospital could afford the risk of accepting DR. MARRESE on its staff. The damage to DR. MARRESE, therefore, would represent no less that $15,000,000.00 over the estimated remainder of his professional career.

WHEREFORE, plaintiffs, DR. MARRESE and BONE & JOINT SURGEONS, INC., pray that this Court enter judgment against defendants, ALLEN, BLOSS, EVANS, PERCINEL, DOMINQUEZ, BAKER, NACHTNEBEL, JOHNSON, RENDER, INTERQUAL, INC. and HOSPITAL and each of them for $16,500,000.00 together with costs of this action.

COUNT VI

1.-56. The allegations of Paragraphs 1 through 56 of Count V are hereby incorporated by reference.

57. The exact amount of plaintiffs' future damages in the event that the acts enumerated above performed by defendants are fully successful, cannot presently be determined. However, his injury will be grave and irreparable. No money damages can ever fully compensate him for this threatened termination of his clinical privileges and his lifelong professional disgrace.

WHEREFORE, plaintiffs, DR. MARRESE and BONE & JOINT SURGEONS, INC., pray that this Court enter a Permanent Injunction restraining said defendants and each of them from all of the aforesaid acts and that is grant them such

other and further relief as it may deem just and proper, together with all costs of this action.

R. ANTHONY MARRESE, M.D. and
BONE & JOINT SURGEONS, INC.

By: /s/ JOHN CASEY
John J. Casey,
One of Their Attorneys

JOHN J. CASEY
LANDESMAN & SCHWARTZ
111 W. Washington Street
Suite 1025
Chicago, Illinois 60602
(312) 346-6650

JURY DEMAND

I, John J. Casey, one of the attorneys for plaintiffs, R. ANTHONY MARRESE, M.D. and BONE & JOINT SURGEONS, INC., hereby demand a trial by jury on the issues listed in this Complaint.

/s/ JOHN J. CASEY
John J. Casey

JOHN J. CASEY
LANDESMAN & SCHWARTZ
Attorneys for Plaintiffs
111 W. Washington Street
Suite 1025
Chicago, Illinois 60602
(312) 346-6650

CERTIFICATE OF DELIVERY

I hereby certify that I have delivered a true and correct copy of the foregoing instrument to the following attorneys of record, in sealed envelopes, addressed as follows:

DENNIS J. HORAN, ESQ.
GEORGE W. SPELLMIRE, ESQ.
HINSHAW, CULBERTSON, MOELMANN,
HOBAN & FULLER
69 W. Washington Street
Chicago, IL 60602

NANCY SCHAEFER, ESQ.
KARON, MORRISON & SAVIKAS
5720 Sears Tower
233 South Wacker Drive
Chicago, IL 60606

RICHARD FRENCH, ESQ.
FRENCH, ROGERS, KEZELIS &
KOMINIAREK, P.C.
33 North Dearborn Street
Chicago, IL 60602

DATED: Chicago, Illinois, this 3rd day of March, 1983.

/s/ JOHN J. CASEY
John J. Casey

JOHN J. CASEY
LANDESMAN & SCHWARTZ
111 W. Washington Street
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(312) 346-6650

UNITED STATES DISTRICT COURT

Northern District of Illinois

Eastern Division

Name of Presiding Judge, Honorable George N. Leighton

Cause No: 82 C 4296 Date: March 18, 1983

Title of Cause: Marrese v. Interqual, et al.

Brief Statement of Motion: Motion for Leave to File Second Amended Complaint, Motion to Reconsider

The rules of this court require counsel to furnish the names of all parties entitled to notice of the entry of an order and the names and addresses of their attorney. Please do this immediately below (separate lists may be appended).

Names and Addresses of moving counsel:

Representing:

Names and Addresses of other counsel entitled to notice and names of parties they represent:

Reserve space below for notations by minute clerk

For the reasons stated in the Memorandum filed herewith, the motion for leave to file a second amended complaint is denied and the court adheres to its ruling of February 28, 1983 dismissing the first amended complaint.

Leighton, *J.* Docketed March 21, 1983

U.S.C.A.—7th Circuit
Received
June 31, 1983
Thomas F. Strubbe
Clerk

IN THE UNITED STATES COURT OF APPEALS
For the Seventh Circuit

No. 83-1581

R. ANTHONY MARRESE, M.D., and BONE & JOINT SURGEONS, INC., *Plaintiffs-Appellants,* *vs.* INTERQUAL, INC., et al., *Defendants-Appellees.*	Appeal from the United States District Court for the Eastern District of Illinois No. 82 C 4296 Honorable George N. Leighton

NOTICE OF MOTION

To: NANCY SCHAFFER
KARON, MORRISON & SAVIKAS, LTD.
5720 Sears Tower
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Chicago, IL 60606

D. KENDALL GRIFFITH
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69 W. Washington Street
Chicago, IL 60602

RICHARD FRENCH
FRENCH, ROGERS, KEZELIS & KOMINIAREK, P.C.
33 N. Dearborn Street
Chicago, IL 60602

PLEASE TAKE NOTICE that on the 21st day of June, 1983, we caused to be filed with the Clerk of the United States Court of Appeals for the Seventh Circuit, Chicago, Illinois, the attached motion, pursuant to Rule 10(e), Federal Rules of Appellate Procedure, to amend the record on appeal and to file a Third Amended Complaint.

/s/ JOHN J. CASEY
John J. Casey

JOHN J. CASEY
LANDESMAN & SCHWARTZ
Attorneys for Plaintiffs-Appellants
111 W. Washington Street
Suite 1025
Chicago, IL 60602
(312) 346-6650

U.S.C.A.—7th Circuit
Received
June 21, 1983
Thomas F. Strubbe
Clerk

IN THE UNITED STATES COURT OF APPEALS
For the Seventh Circuit

No. 83-1581

R. ANTHONY MARRESE, M.D., and BONE & JOINT SURGEONS, INC., *Plaintiffs-Appellants,* *vs.* INTERQUAL, INC., *et al.,* *Defendants-Appellees.*	Appeal from the United States District Court for the Eastern District of Illinois No. 82 C 4296 Honorable George N. Leighton

MOTION

R. Anthony Marrese, M.D., and Bone & Joint Surgeons, Inc., by their attorney, John J. Casey, of the firm of Landesman & Schwartz, pursuant to Rule 10(e), Federal Rules of Appellate Procedure, move this honorable Court to permit plaintiffs to amend the record on appeal to include plaintiffs' Second Amended Complaint and plaintiffs' Motion to file a third amended complaint and in support thereof state as follows:

One: On March 18, 1983, an order was entered by the district judge denying plaintiffs' motion to file a second amended complaint and adhering to the Court's ruling of February 28, 1983, dismissing the First Amended Complaint. That Order and Memorandum appear in the record as R.79. The Memorandum, page 2, refers to the Second Amended Complaint.

Two: For the purpose of this filing, the Second Amended Complaint has been marked R.84.

Three: On March 25, 1983, plaintiff filed a motion, which, amongst other things, advised the Court of certain matters that they wished to insert in a third amended complaint. On March 25, 1983, that motion was denied in so far as leave was sought to file a third amended complaint. The Minute Order bearing that date is presently in the record as R.81.

Four: For the purpose of this motion and the record the motion of March 25, 1983, has been assigned No. R.85.

Five: The inclusion of these items in the record is necessary so that this Court will have a full picture of the facts before it and before the District Court.

WHEREFORE, R. Anthony Marrese and Bone & Joint Surgeons, Inc., move this honorable Court for leave to amend the record on appeal to include plaintiffs' Second Amended Complaint and plaintiffs' motion to file a third amended complaint.

Respectfully submitted,

R. ANTHONY MARRESE, M.D., and
BONE & JOINT SURGEONS, INC.,

By: /s/ JOHN J. CASEY
John J. Casey,
One of Their Attorneys

JOHN J. CASEY
LANDESMAN & SCHWARTZ
Attorneys for Plaintiffs-Appellants
111 W. Washington Street
Suite 1025
Chicago, IL 60602
(312) 346-6650

AFFIDAVIT OF SERVICE

STATE OF ILLINOIS }
COUNTY OF COOK } ss.:

JOHN J. CASEY, being first duly sworn on oath, deposes and says that he served the foregoing instrument upon:

NANCY SCHAFFER
KARON, MORRISON & SAVIKAS, LTD.
5720 Sears Tower
233 S. Wacker Drive
Chicago, IL 60606

D. KENDALL GRIFFITH
HINSHAW, CULBERTSON, MOELMANN,
HOBAN & FULLER
69 W. Washington Street
Chicago, IL 60602

RICHARD FRENCH
FRENCH, ROGERS, KEZELIS &
KOMINIAREK, P.C.
33 N. Dearborn Street
Chicago, IL 60602

by mailing true and correct copies of the same this 21st day of June, 1983, and by depositing the said copies in the United States Mail at 111 W. Washington Street, Chicago, Illinois, 60602, postage prepaid, addressed as above shown.

/s/ JOHN J. CASEY

SUBSCRIBED and SWORN to before me this 21st day of June, 1983.

K. L. JAQUET
Notary Public

JOHN J. CASEY
Landesman & Schwartz
111 West Washington Street
Suite 1025
Chicago, Illinois 60602
(312) 346-6650

The Indiana Immunity—Privileged Communication Professionals and Peer Review Committees Ind Code §§ 34-4-12.6-1(b)-(f); 34-4-12.6-2(a)-(d), 34-4-12.6-3(a)-(d), 34-4-12.6-4

Ind. Code 34-4-12.6-1. Definitions.

(b) As used in this chapter, "evaluation of patient care" relates to:

(1) The accuracy of diagnosis;

(2) The propriety, appropriateness, or necessity of care rendered by a professional health care provider; and

(3) The reasonableness of the utilization of services, procedures and facilities in the treatment of individual patients.

As used in this chapter, the term does not relate to charges for services nor to methods used in arriving at diagnoses.

(c) As used in this chapter, "peer review committee" means a committee having the responsibility of evaluation of qualifications of professional health care providers, or of patient care rendered by professional health care providers, or of the merits of a complaint against a professional health care provider that includes a determination or recommendation concerning the complaint. The committee must meet the following criteria:

(1) The committee is organized:

(A) By a state, regional, or local organization of professional health care providers or by a not-for-profit foundation created by such a professional organization for purposes of improvement of patient care;

(B) By the professional staff of a hospital or other health care facility;

(C) By state or federal law or regulation; or

(D) As a governing board of a hospital or professional health care organization.

(2) A majority of the members of the committee are professional health care providers holding licenses in the stated profession of the committee, or the governing board of a hospital or professional health care organization. However, "peer review committee" does not include a medical review panel created under IC 16-9.5-9.1.

(d) As used in this chapter, "professional staff" means all professional health care providers holding licenses in a single profession, authorized to provide health care in a hospital or other health care facility.

(e) As used in this chapter, "personnel of a peer review committee" means not only members of the committee but also all of the committee's employees, representatives, agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serves a peer review committee in any capacity.

(f) As used in this chapter, "in good faith" refers to an act taken without malice after a reasonable effort to obtain the facts of the matter and in the reasonable belief that the action taken is warranted by the facts known. In all actions to which this chapter applies, good faith shall be presumed; and malice shall be required to be proven by the person aggrieved.

(g) As used in this chapter, "professional health care organization" means an organization composed of professional health care providers.

Ind. Code 34-4-12.6-2. Confidentiality and privilege.—(a) All proceedings of a peer review committee shall be confidential, and all communications to a peer review committee shall be privileged communications to the peer review com-

mittee. Neither the personnel of a peer review committee nor any participant in a proceeding therein shall reveal any content of communications to, or the records or determination of, a peer review committee outside the peer committee. However, the governing board of a hospital or professional health care organization may disclose the final action taken with regard to a professional health care provider without violating the provisions of this section. Except as otherwise provided in this chapter, no person who was in attendance at any such peer review committee proceeding shall be permitted or required to disclose any information acquired in connection with or in the course of such proceeding, or to disclose any opinion, recommendation, or evaluation of the committee or of any member thereof. Information otherwise discoverable or admissible from original sources is not to be construed as immune from discovery or use in any proceeding merely because it was presented during proceedings before such peer review committee, nor is a member, employee, or agent of such committee or other person appearing before it to be prevented from testifying as to matters within his knowledge and in accordance with the other provisions of this chapter, but the witness cannot be questioned about this testimony or other proceedings before such committee or about opinions formed by him as a result of committee hearings.

(b) Any professional health care provider under investigation shall be permitted at any time to see any records accumulated by a peer review committee pertaining to his personal practice and shall be offered the opportunity to appear before the peer review committee with adequate representation to hear all charges and findings concerning his practice and to offer rebuttal information, which shall be a part of the record before any disclosure of the charges and findings under this chapter. However, a professional health care provider under investigation in a hospital is entitled to only one [1] evidentiary hearing before a peer review committee of the medical staff and one [1] additional hearing on appeal before the governing

board of the hospital. Communications to, and the records and determinations of, a peer review committee may only be disclosed to the peer review committee of a hospital or other health facility, the disciplinary authority of the professional organization of which the professional health care provider under question is a member, or the appropriate state board of registration and licensure which the committee considers necessary for recommended disciplinary action, and shall otherwise be kept confidential for use only within the scope of the committee's work.

(c) Except in cases of required disclosure as authorized in this chapter, no records or determinations of, or communications to, a peer review committee shall be:

(1) Subject to subpoena or discovery; or

(2) Admissible in evidence;

in any judicial or administrative proceeding, including a proceeding under IC 16-9.5-10, without a prior waiver executed by the committee. Except in cases as authorized in this chapter, the evidentiary privileges created by this section shall be invoked by all witnesses and organizations in all judicial and administrative proceedings unless the witness or organization first has a waiver of the privilege executed in writing, on behalf of the peer review committee holding the privilege, by its chairman, vice chairman, or secretary.

(d) The immunities granted by section 3[34-4-12.6-3] of this chapter shall not extend to any person who violates the confidentiality requirements of this section.

Ind. Code 34-4-12.6-3. Immunity.—(a) There shall be no liability on the part of, and no action of any nature shall arise against, the personnel of a peer review committee for any act, statement made in the confines of the committee, or proceeding thereof made in good faith in regard to evaluation of patient care as that term is defined and limited in section 1(b) [34-4-12.6-1(b)] of this chapter.

(b) Persons or organizations, including peer review committees, who, in good faith, furnish records, information or assistance to a peer review committee, in regard to evaluation of qualifications of professional health care providers, or of patient care as that term is defined and limited in section 1(b) of this chapter, shall be immune from any civil action arising from such acts.

(c) The personnel of a peer review committee shall be immune from any civil action arising from any determination made in good faith in regard to evaluation of patient care as that term is defined and limited in section 1(b) of this chapter.

(d) No restraining order or injunction shall be issued against a peer review committee or any of the personnel thereof to interfere with the proper functions of the committee acting in good faith in regard to evaluation of patient care as that term is defined and limited in section 1(b) of this chapter.

Ind. Code 34-4-12.6-4. Use of information obtained by peer review committees.—A professional health care provider, a peer review committee, and the governing board of a hospital or professional health care organization may use information obtained by peer review committees for legitimate internal business purposes, including their own defense.

Indiana Medical Licensing Board

Ind. Code 25-22.5-2-1. Creation and membership [effective July 1, 1982].—The medical licensing board of Indiana is created. It shall consist of seven [7] members, not more than four [4] of whom shall be members of the same political party. The members shall be appointed by the governor, and all vacancies occurring on the board shall be filled by the governor. The membership of the board shall consist of:

(1) Five [5] reputable physicians who are graduates of a medical school who hold the degree of doctor of

medicine or its equivalent and who hold valid unlimited licenses to practice medicine in Indiana, and who shall serve for terms of four [4] years each;

(2) One [1] reputable osteopathic physician who is a graduate of an accredited osteopathic medical school who holds the degree of doctor of osteopathy or its equivalent and who holds a valid unlimited license to practice osteopathic medicine in Indiana, who shall serve for a term of four [4] years; and

(3) One [1] member to represent the general public who is a resident of this state and in no way associated with the medical profession other than as a consumer.

Ind Code § 25-22.5-2-7. Powers and duties [effective July 1, 1982].—The board shall:

(a) Promulgate rules, regulations and forms necessary to implement this article. It may adopt rules and regulations concerning, but not limited to, the following areas:

(i) Qualification by education, residence, citizenship, training and character for admission to an examination for licensure or by endorsement for licensure;

(ii) The examination for licensure itself;

(iii) The license or permit itself;

(iv) Fees for examination, permit, licensure, and registration; and

(v) Reinstatement of licenses and permits;

(b) Administer oaths in matters relating to the discharge of their official duties;

(c) Enforce this article, and assign service bureau personnel duties, as may be necessary in the discharge of the board's duty;

(d) Maintain, through the service bureau, full and complete records of all applicants for licensure or permit and of all licenses and permits issued;

(e) Make available, upon request, the complete schedule of minimum requirements for licensure or permit;

(f) Have the power to issue a temporary permit to an applicant for the interim from the date of application until the next regular meeting of the board;

(g) Have the duty to issue an unlimited license, a limited license or a permit, depending upon the qualifications of the applicant, to any applicant who successfully fulfills all of the requirements of this article; and

(h) Adopt rules establishing standards for the competent practice of medicine or osteopathic medicine, or any other form of practice regulated by a limited license or permit issued under this article. [IC 25-22.5-2-7, as added by Acts 1975, P.L. 271, § 1; 1981, P.L. 222, § 154.]

Indiana Medical Licensing Requirements

Ind. Code § 25-22.5-3-1. Minimum requirements [effective July 1, 1982].—The minimum requirements for all applicants for an unlimited license to practice medicine or osteopathic medicine in Indiana must include but are not limited to the following:

(a) [Repealed.]

(b) The applicant must not have a conviction for an act which would constitute a ground for disciplinary sanction under IC 25-22.5-6-2.1(b).

(c) The applicant shall possess the degree of doctor of medicine or doctor of osteopathy or its equivalent from a medical school which was approved by the board as of the time the degree was conferred.

(d) The applicant shall have successfully passed the examination for licensure or shall have satisfied the requirements for licensure by endorsement as prescribed by the board.

(e) The applicant shall be physically and mentally capable of safely engaging in the practice of medicine or osteopathic medicine and shall submit to an examination if deemed necessary by the board to determine such capability.

(f) [Repealed.]

(g) The applicant shall not have had his license previously revoked or suspended by the board or by the licensing agency of any other state by reasons of his inability to safely practice medicine or osteopathic medicine, and those reasons are still valid in the opinion of the board.

(h) The applicant shall have submitted a complete transcript of his educational records, grades and diploma from his medical school with an English translation thereof.

(i) The applicant shall, at the board's discretion, make a personal appearance before it.

Probation, Suspension and Revocation of a Medical License

Ind. Code § 25-22.5-6-2.1. Disciplinary sanctions [effective July 1, 1982].—(a) As used in this section and section 3[25-22.5-6-3] of this chapter, "practitioner" means an individual who holds an unlimited license, limited license, or permit issued under this article.

(b) A practitioner shall conduct his practice in accordance with the standards established by the board under IC 25-22.5-

2-7(h) and is subject to the exercise of the disciplinary sanctions under subsection (e) if, after a hearing, the board finds:

(1) The practitioner has employed or knowingly cooperated in fraud or material deception in order to obtain a license to practice, or has engaged in fraud or material deception in the course of professional services or activities, or has advertised services in a false or misleading manner;

(2) The practitioner has been convicted of a crime which has a direct bearing on the practitioner's ability to continue to practice competently;

(3) A practitioner has knowingly violated any rule adopted by the board under IC 25-22.5-2-7(h);

(4) A practitioner has continued to practice although he has become unfit to practice due to:

(A) Professional incompetence;

(B) Failure to keep abreast of current professional theory or practice;

(C) Physical or mental disability; or

(D) Addiction or severe dependency upon alcohol or other drugs which endangers the public by impairing a practitioner's ability to practice safely;

(5) A practitioner has engaged in a course of lewd or immoral conduct in connection with the delivery of services to patients;

(6) A practitioner has allowed his name or license issued to him under this chapter to be used in connection with any individual who renders services beyond the scope of his training, experience, or competence.[;]

(7) A practitioner, except as otherwise provided by law, has knowingly prescribed, sold, or administered any

drug classified as a narcotic, addicting, or dangerous drug to a habitué or addict; or

(8) A practitioner has had a license to practice in another state revoked or suspended by that state on grounds similar to those under this section. A certified copy of the record of suspension or revocation is conclusive evidence of the other state's suspension or revocation.

(c) The board may order a practitioner to submit to a reasonable physical or mental examination if his physical or mental capacity to practice safely is at issue in a disciplinary proceeding.

(d) Failure to comply with a board order to submit to a physical or mental examination shall render a practitioner liable to the summary revocation procedures under subsection (f) [of this section].

(e) The board may impose any of the following sanctions, singly or in combination, when it finds that a practitioner is guilty of any offense under subsection (b) [of this section]:

(1) Permanently revoke a practitioner's license;

(2) Suspend a practitioner's license;

(3) Censure a practitioner;

(4) Issue a letter or reprimand; or

(5) Place a practitioner on probation status and require the practitioner to:

(A) Report regularly to the board upon the matters which are the basis of probation;

(B) Limit practice to those areas prescribed by the board; or

(C) Continue or renew professional education under a preceptor approved by the board until satis-

factory degree of skill has been attained in those areas which are the basis of the probation.

The board may withdraw the probation if it finds that the deficiency which required disciplinary action has been remedied.

(f) The board may summarily suspend a practitioner's license for a period of ninety [90] days in advance of a final adjudication or during the appeals process if the board finds that a practitioner represents a clear and immediate danger to the public health and safety if he is allowed to continue to practice. The summary suspension may be renewed upon a hearing before the board, and each renewal may be for a period of ninety [90] days or less.

(g) The board may reinstate a license which has been suspended under this chapter if, after a hearing, the board is satisfied that the applicant is able to practice with reasonable skill and safety to patients. As a condition of reinstatement, the board may impose disciplinary or corrective measures authorized under this chapter.

(h) The board shall seek to achieve consistency in the application of the sanctions authorized in this section, and significant departures from prior decisions involving similar conduct shall be explained in the board's findings or orders. [IC 25-22.5-6-2.1, as added by Acts 1981, P.L. 222, § 156.]

Ind. Code 25-22.5-6-3. Disciplinary proceedings [effective July 1, 1982].—(a) Proceedings for the disciplining of a practitioner under section 2.1 [25-22.5-6-2.1] of this chapter must be commenced by the filing of written verified charges with the secretary of the board. Subject to IC 25-1-7 [25-1-7-1—25-1-7-11], these charges may be filed by any resident of Indiana, or by the secretary or any member of the board upon information from whatever source in his possession, which causes the member to have reasonable cause to believe that the matter should be filed and placed before the board for its

determination. Proceedings for disciplinary actions must be conducted according to the administrative adjudication act of Indiana, IC 4-22-1 [4-22-1-1—4-22-1-30]. Approval by a majority of all members of the board shall be required for any action to be taken.

(b) Any person who files charges or testifies before the board in any disciplinary proceeding is immune from civil liability for damages for any sworn or written testimony made with probable cause and without malice.

(c) The administrator, his staff, counsel, investigators, hearing officers, and the board members are immune from civil liability for damages for conduct within the scope and arising out of the performance of their duties.

Hospital Licensing and Regulation

Ind. Code § 16-10-1-1. Licensing of hospitals—From and after the passage of this chapter the state board of health shall be empowered to license and regulate hospitals and ambulatory outpatient surgical centers. Such licensing and regulations shall be accomplished through a council to be created in the manner hereinafter provided, and such other employees as are hereinafter provided for.

Ind. Code 16-10-1-10 [ ]. Suspension or revocation of license—Procedure.—The board may suspend or revoke a license issued hereunder on the recommendation of the council on any of the following grounds:

(a) Violation of any of the provisions of this chapter or of the rules and regulations issued pursuant hereto;

(b) Permitting, aiding, or abetting the commission of any illegal act in such institution; or

(c) Conduct or practice found by the council to be detrimental to the welfare of the patients of such institution.

The procedure governing the suspension or revocation of any license shall be as follows:

(1) A complaint shall be filed by the board stating facts constituting a ground or grounds for revocation or suspension.

(2) The licensee shall be given notice of not less than thirty [30] days of the time and place for a hearing before the council on said complaint, which notice shall be sent by registered mail to the licensee at the address shown in his application. The licensee shall be entitled to be represented by legal counsel at said hearing.

(3) The council may recommend to the board after such hearing either that the license be suspended or that it be revoked.

(4) If the council recommends suspension of a license it may also recommend the conditions to be met by the licensee during the period of suspension in order to entitle the licensee to resume operation of the said hospital or ambulatory outpatient surgical center on the existing license.

(5) If the council recommends either suspension or revocation the board shall, pursuant thereto, enter an order in accordance therewith in which order shall be set forth the grounds of such suspension or revocation.

(6) The council may, in its discretion, after hearing, hold the case under advisement and make a recommendation to the board as to requirements to be met by said licensee in order to avoid either suspension or revocation; and in such cases the board shall enter an order accordingly and notify the licensee

thereof by registered mail. Then if the licensee complies with such order and proves that fact to the satisfaction of the council, the council shall recommend to the board that an order be entered showing satisfactory compliance and dismissing the case because of such compliance, and the board shall enter such an order.

Ind. Code 16-10-1-2 Definitions.—The word "board" as used in this act [16-10-1-1—16-10-1-19], unless otherwise indicated, shall mean the state board of health. The word "council," unless otherwise indicated, shall mean the council herein provided for.

Ind. Code 16-10-1-3 Council—Composition—Term—Vacancy. The council shall consist of eight [8]members, who shall be appointed by the governor within thirty [30] days after this act [16-10-1-1—16-10-1-19] becomes effective, one [1] of whom shall be a member of the medical profession having an unlimited license to practice medicine in the state of Indiana, one [1] of whom shall be a registered nurse, four [4] of whom shall be persons engaged in hospital administration. The two [2] remaining members shall be ex officio members, one [1] of whom shall be appointed by the governor from the state department of public welfare, and the other of whom shall be appointed from the state board of health. Of the original hospital administrators appointed one [1] shall serve for one [1] year, one [1] for two [2] years, one [1] for three [3] years, and one [1] for four [4] years. The original members appointed from the medical profession and the nursing profession shall serve for three [3] years. The members appointed from the department of welfare and board of health shall serve for two [2] years. All subsequent appointments shall be for four [4] years, except that in case of a vacancy the appointee shall serve for the remainder of the unexpired term. Any vacancy shall be filled from the same group as was represented by the outgoing member. The governor shall appoint a chairman and a chairman pro tempore.

16-10-1-11. Appeal to courts.—Any licensee, or applicant for a license, aggrieved by the action of the council and the board may appeal from such action to the circuit or superior court of the county in which the hospital or ambulatory outpatient surgical center in question is located, or is proposed to be located, by filing a notice and bond in the amount of two hundred dollars [$200] for the payment of costs, in the office of the county clerk of such county, who shall thereupon notify the board that such appeal has been taken. The board shall thereupon cause to be certified to such court a copy of the complaint and of the recommendation of the council and the order of the board in cases of suspension or revocation; or of the application and order of refusal of a license, in any case where a license was refused. The case shall then be docketed as a civil action, with the applicant or licensee as the plaintiff and the board as the defendant. No further pleading shall be necessary. Such court shall have jurisdiction to the extent that courts exercise jurisdiction over administrative bodies and may enter an order either sustaining the action of the board and council or setting it aside. The clerk of such court shall certify to the board a copy of the decision of such court. An appeal may be had from the decision of such court. [Acts 1945, ch. 346, § 11, p. 1639; 1972, P.L. 111, § 6.]

Ind. Code 16-10-1-6.5. Management of hospital—Appointment to Medical staff—Medical review—Civil liability.—The governing board of the hospital [hospital] shall be the supreme authority in the hospital, responsible for the management, operation, functioning and control of the hospital, and the appointment of the members of the medical staff and the assignment of privileges to members of the medical staff with the advice and recommendations of the medical staff consistent with their individual training, experience, and other qualifications. The medical staff of a hospital shall be an organized group which shall be responsible to the governing board for the clinical and scientific work of the hospital, advice regarding professional matters and policies to the governing

board, and shall have the responsibility of reviewing the professional practices in the hospital for the purpose of reducing morbidity and mortality, and for the improvement of the care of patients in the hospital. This review shall include, but shall not be limited to, the quality and necessity of the care provided patients and the preventability of complications and deaths occurring in the hospital. The members of any medical staff committee organized for the purpose of conducting medical review, being retrospective and not a part of current patient care, shall have an absolute immunity from civil liability for communications made in committee meetings, and reports and recommendations made by the committee arising from deliberations by the committee to the governing board of the hospital or another duly authorized medical staff committee. [IC 16-10-1-6.5, as added by Acts 1971, P.L. 217, § 1.]

Ind. Code 16-10-1-6.5. Management of hospital—Medical staff—Medical review—Civil liability.—(a) The governing board of the hospital shall be the supreme authority in the hospital, responsible for:

(1) The management, operation, functioning, and control of the hospital;

(2) The appointment and reappointment of the members of the medical staff, and the assignment of privileges to members of the medical staff, with the advice and recommendations of the medical staff, consistent with their individual training, experience, and other qualifications; and

(3) Establishing requirements for initial and subsequent appointments to and continued service on the hospital's medical staff, consistent with the appointee's individual training, experience, and other qualifications, including such requirements as:

(A) The submission of proof that a medical staff member has qualified as a health care provider under IC 16-9.5;

(B) The performance of patient care and related duties in a manner that is not disruptive to the delivery of quality medical care in the hospital setting; and

(C) Standards of quality medical care which recognize the efficient and effective utilization of hospital resources, as developed by the medical staff.

(b) The governing board shall report, in writing, to the Indiana medical licensing board the results and circumstances of any final, substantive, and adverse disciplinary action taken by the governing board regarding a physician on the medical staff, or an applicant for the medical staff, if the action results in voluntary or involuntary resignation, termination, nonappointment, revocation, or significant reduction of clinical privileges or staff membership. Such a report shall not be made for nondisciplinary resignations nor for minor disciplinary action taken regarding physicians. The governing board and its employees, agents, consultants, and attorneys have absolute immunity from civil liability for communications, discussions, actions taken, and reports made concerning disciplinary action or investigation taken or contemplated, if such reports or actions are made in good faith and without malice.

(c) The medical staff of a hospital shall be an organized group which shall be responsible to the governing board for the clinical and scientific work of the hospital, advice regarding professional matters and policies to the governing board, and shall have the responsibility of reviewing the professional practices in the hospital for the purpose of reducing morbidity and mortality, and for the improvement of the care of patients in the hospital. This review shall include, but shall not be limited to, the quality and necessity of the care provided patients and the preventability of complications and deaths occurring in the hospital.

(d) The members of any medical staff committee organized for the purpose of conducting medical review, being

retrospective and not a part of current patient care, shall have an absolute immunity from civil liability for communications made in committee meetings, and reports and recommendations made by the committee arising from deliberations by the committee to the governing board of the hospital or another duly authorized medical staff committee.

Amendments. The 1983 amendment designated the existing language as present subsections (a), (c), and (d); and added subsection (b).

The 1984 amendment in subsection (a), added subdivision designations (1) and (2), deleted "and" from the end of subdivision (1), inserted "and reappointment" in subdivision (2), and inserted subdivision (3).

Effective Dates. P.L.187-1983, § 8(a) declared an emergency. Approved April 22, 1983.

Indiana Administrative Code Rule 1. Hospital Operation, Management, Construction Equipment Requirements 410 2A [15-1-8—DOCUMENTS, REPORTS AND RECORDS. (1) Documents and records which show ownership and compliance with local, state and federal laws and regulations and adherence to bylaws and regulations of the facility shall be maintained within the hospital and shall be made available for examination by duly authorized representatives of the Council and the Board of Health. Items to be maintained are:

* * *

(c) Minutes of meetings of both the Governing Body, Medical Staff, and their committees thereof; such minutes shall be considered confidential.

* * *

(e) A completed application for each member of the Medical Staff which includes the following data: Date of application, professional education and training by school and year, date of licensure, and number thereof in Indiana, Drug Enforcement Administration number, experience in the practice of medicine, type of Medical Staff appointment and delineation of privileges desired, Medicaid provider number, if one is assigned, pledge to abide by rules and regulations of the hospital, and other items specified by the hospital and its Medical Staff.

IN THE COURT OF APPEALS OF INDIANA

No. 1-883 A247

R. ANTHONY MARRESE,
Appellant-Plaintiff,

vs.

DEACONESS HOSPITAL, INC., THOMAS J. RUSCHE, RONALD W. SOWA, RICHARD WAGNER, RALPH F. CARLSON, ROBERT PENKAVA, WILLIAM D. POWELL,
Appellees-Defendants.

Appeal from the Vanderburgh County Circuit Court Cause No. 9454

The Honorable William H. Miller, Judge

BRIEF OF APPELLANT

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WILLIAM D. POWELL,
Appellees-Defendants.

BRIEF OF APPELLANT

I.

Issues Presented for Review

1. Whether the trial court erred as a matter of law when it determined in its order of July 8, 1983 that the hearing committee appointed by the President of the Appellee Hospital staff to consider whether to recommend that Appellant's staff privileges should be revoked is a peer review committee within the meaning of the Indiana Peer Review Act, I.C. 34-4-12.6-1 *et seq.*

2. Whether the trial court abused its discretion in holding that the hearing committee appointed by the President of the Appellee Hospital medical staff to consider whether to recommend revocation of Appellant's staff privileges was not proceeding maliciously and therefore could not be enjoined under I.C. 34-4-12.6-3, when all of the evidence presented at the hearing on the Motion for Preliminary Injunction could, as a matter of law, lead only to a conclusion that the committee was acting with malice.

3. Whether the Indiana Peer Review Act, I.C. 34-4-12.6-1 *et seq.* violates the Fourteenth Amendment of the United States Constitution and Article I, Section 12 of the Indiana Constitution for the reason that the Act improperly limits the civil liability of participants in peer review proceedings and the personnel of a peer review committee, impermissibly limits the ability of parties involved in civil litigation to obtain discovery of peer review records and proceedings and of participants in peer review proceedings, and unlawfully restricts the ability of interested parties to enjoin or otherwise restrain peer review proceedings even when the peer review committee is not proceeding in compliance with the law.

II.

Statement of the Case

The Appellant, R. Anthony Marrese, filed a Verified Complaint for Injunction on July 7, 1983 against the Appellees, seeking to enjoin Appellees from conducting a hearing scheduled for July 9, 1983 to consider a recommendation that Appellant's staff privileges at Deaconess Hospital should be revoked. (Tr. 11, 251) In his Complaint the Appellant requested that the Court issue a temporary restraining order, preliminary injunction and permanent injunction prohibiting Appellees from conducting the hearing scheduled for July 9, 1983.

On July 8, 1983 Appellants request for a preliminary injunction came on for hearing before the Court in the form of a Motion for Preliminary Injunction. Following a hearing at which evidence was presented by the parties, the Court entered an order denying Appellant's Motion for Preliminary Injunction. (Tr. 107)

On August 3, 1983 the Appellant filed his Praecipe for Transcript with the Clerk of the Vanderburgh Circuit Court.

(Tr. 109) The Pre-Appeal Statement, including the assignment of errors, (Tr. 1) was timely filed with this Court on August 15, 1983. On August 11, 1983 this Court granted Appellant's Verified Petition for an Exension of Time within which to File the Record of Proceedings to and including August 29, 1983. The record of proceedings was timely filed with the Clerk of the Supreme Court and Court of Appeals on August 29, 1983. On September 12, 1983 this Court granted Appellant's Verified Petition for an Extension of Time Within Which to File Appellant's Brief on Appeal to and including September 28, 1983. Appellant brings this interlocutory appeal before this Court pursuant to Appellate Rule 4(B)(3).

III.

Statement of Relevant Facts

The Appellant, R. Anthony Marrese, is licensed to practice medicine in the State of Indiana and is a board certified orthopedic surgeon. (Tr. 114) At the time of hearing he was a member of the medical staffs of Deaconess Hospital, St. Marys Medical Center and Welborn Baptist Memorial Hospital, all of which are located in Evansville, Indiana. (Tr. 116) Appellant specializes in disorders of the spine and in all areas of orthopedic surgery. (Tr. 114-116)

The Appellant began his practice in Evansville in early 1973, and was associated with another orthopedic surgeon, Bryant Bloss, for approximately two years. (Tr. 115-117) When the Appellant and Dr. Bloss terminated their business relationship, the Appellant retained counsel to assist him regarding certain questions which arose concerning the distribution of corporate assets and other legal matters. (Tr. 117) The termination of the business relationship was not harmonious. The attorney who served as Appellant's counsel in that matter was Mr. William Powell of Evansville. (Tr. 117) Following the termination of his partnership with Dr. Bloss, the Appellant has been in practice alone.

From 1973 until early 1978 the Appellant served as a member of the Appellee Deaconess Hospital staff without experiencing any professional difficulties. (Tr. 118) Then, in February 1978, Dr. Allen, who was then Chairman of the Appellee Hospital Medical Staff Executive Committee, recommended that an audit be performed of "back surgery" and that the audit be conducted by the Hospital's Medical Audit Committee. (Tr. 119) The audit, however, was not performed by the Medical Audit Committee because Appellant served on the Committee. (Tr. 119) Instead, a special ad hoc committee was established to conduct an audit of all back surgery performed at the Hospital. (Tr. 119)

The special ad hoc audit committee performed two separate audits. One audit was conducted on lumbar laminectomies and the other on lumbar spine fusions performed at the Hospital. (Tr. 119-120) The audits conducted by the special ad hoc committee approved the laminectomies performed at the Hospital even though only sixty-eight percent (68%) of said procedures met nationally established criteria. (Tr. 120) On the other hand, the committee recommended additional study of the spinal fusions performed at Appellee Hospital despite the fact that ninety percent (90%) of such procedures met nationally prescribed standards. (Tr. 120) Interestingly enough, Appellant is the individual who performs the majority of spinal fusions at the Hospital. (Tr. 120) No final action was taken against the Appellant at that time as a result of the study completed by the special ad hoc audit committee. (Tr. 120)

Then, in early 1980 the Appellant received a letter from Dr. Allen informing him that as a result of the special ad hoc committee's review, the Appellant's performance would be discussed on a case by case basis. (Tr. 120) Appellant met with the committee on one occasion, at which only a single case was discussed. (Tr. 121) The Appellee Hospital then decided to appoint Appellant's former associate, Dr. Bloss, and another physician to the special ad hoc audit committee. This is the

same Dr. Bloss from whom Appellant had severed business ties in an unfriendly fashion. (Tr. 208) Both Dr. Bloss and the other physician have now been witnesses against the Appellant in the disciplinary matter. Tr. 115-117, 121)

The special ad hoc audit committee, even with the addition of the two physicians, was still unable to reach any conclusions. (Tr. 121) No action was taken by the Hospital or its committee against Appellant. (Tr. 121) The Hospital then removed about eight cases from the cases originally reviewed by the special ad hoc committee and sent them to an outside auditor. (Tr. 121, 123) These eight cases were reviewed by the outside auditor, but he was similarly unable to arrive at any firm conclusion regarding the appropriateness of Appellant's patient care. (Tr. 123)

Next, the Hospital obtained the services of an independant and private auditing firm, InterQual, located in Chicago, Illinois. (Tr. 123-124) InterQual conducted an off-site evaluation of ninety-three (93) of Appellant's cases, and recommended that Appellant be required to reply to the results of the audit, and that possibly his privileges be withdrawn. (Tr. 124) InterQual completed its report in early 1982. (Tr. 124) It did not, however, utilize current data and instead analyzed patient care rendered by Appellant during the year 1980. (Tr. 124)

In March 1982, Appellant received a letter from the Appellee Hospital stating that he was the subject of a review based upon the report rendered by InterQual. (Tr. 140-141) At a meeting of the Medical Staff Executive Committee held on April 28, 1982 the committee voted to recommend the revocation of Appellant's staff membership and clinical privileges at the Hospital. (Tr. 140-143) Then, on April 19, 1982 the Appellant was informed by Dr. Nachtnebel, Chairman of the Medical Staff Executive Committee, that the committee had voted to recommend the revocation of Appellant's staff membership and clinical privileges at the hospital. (Tr. 140-143) Appellant was also informed, in Nachtnebel's letter, of his

right to a "fair hearing" pursuant to the By-laws and Fair Hearing Plan adopted by the Hospital medical staff. (Tr. 142-143) Finally, Appellant was provided, in skeleton outline, with a short statement of the charges upon which the recommendation was based. (Tr. 143)

Appellant requested a fair hearing pursuant to the Hospital By-laws and was advised by letter dated July 9, 1982 that a fair hearing would be held, before a hearing committee appointed by Dr. Nachtnebel, now the President of the Hospital staff, on July 24, 1982. (Tr. 141, 145) He was also informed by the July 9 letter of the identity of the persons who would comprise the hearing committee and of the specific issues which would be considered at the hearing. (Tr. 146)

The July 24, 1982 hearing was continued pursuant to Appellant's request for additional time to prepare for hearing. (Tr. 145, 169) Despite the fact that Appellant submitted his request for continuance nearly three weeks before the July 24 hearing date, he was not notified of the postponement until just two days before the hearing date. (Tr. 145, 169) Thus, Appellant was put to the trouble of preparing for the hearing. (Tr. 145) Appellant and the Hospital then discussed the possibility of holding the hearing on either August 22-23, 1982 or October 17-18, 1982. (Tr. 169) The proposed dates were acceptable to Appellant. However, the Hospital took no action with regard to this matter until Appellant himself requested a fair hearing pursuant to the fair hearing plan, on May 4, 1983. (Tr. 166, 169, 187, 188, 253, 254)

On May 4, 1983 the Appellant requested, pursuant to the Hospital's By-laws, that the hearing committee set a hearing date within thirty to forty-five days after receipt of said request. (Tr. 91, 169, 187, 188, 253, 254) The Appellant was notified by letter dated June 13, 1983 that the hearing would be held on July 9, 1983 which was more than sixty days from the date of the May 4 request. (Tr. 182) On May 18, 1983 Appellant was notified by the President of the Hospital Professional Staff that

Drs. Thomas J. Rusche, Ronald W. Sowa, Richard Wagner, Ralph F. Carlson and Joseph C. Lawrence were to comprise the hearing committee appointed pursuant to the fair hearing plan. (Tr. 177-181) Shortly thereafter, Appellee, Robert Penkava was also appointed to the hearing panel. In addition, the May 18 notice also informed Appellant that the hearing panel would be advised by the firm of Frick and Powell and the Appellee William Powell in particular. (Tr. 177-181)

Finally, Appellant was notified in the May 18, 1983 correspondence that the charges against him had been amended to include allegations that he engaged indisruptive behavior at the Hospital. (Tr. 177-181) This pattern of conduct, according to the notice, is illustrated by incidents involving, among others, Dr. D. J. Carlson and Dr. Sam B. Baker. (Tr. 180) One of the incidents cited as an example of disruptive behavior involved allegations that Appellant illegally refused to return certain X-rays to Deaconess Hospital. (Tr. 180) This incident was the subject of a lawsuit which was settled amicably by the parties out of court. (Tr. 165-167) Much to Appellant's surprise, the Appellees cited such incident as one of the grounds for the allegation that he had engaged in disruptive behavior. (Tr. 165-167) These allegations of disruptive behavior were added to the charges without prior notice to Appellant. (Tr. 165-167).

The Appellant expressed his objections to the composition of the fair hearing panel. (Tr. 164-167, 148-159, 216) One of the panel members, Dr. Ralph F. Carlson, is the father of Dr. D. J. Carlson, who is one of the individuals accusing Appellant of engaging in disruptive behavior and who was scheduled to testify at the fair hearing. (Tr. 158, 216) In addition, there is documentary evidence that another member of the committee, Dr. Rusche, has strong personal biases against orthopedic surgeons performing spinal surgery. (Tr. 148-153) It was Appellant's belief that such professional territorialism clearly would interfere with Dr. Rusche's ability to evaluate the evidence in an objective manner. (Tr. 148-152)

Similarly, Appellant objected to the fact that Dr. Robert Penkava is a partner in medical practice with Dr. Sam Baker, who was at one time scheduled to testify against Appellant at the fair hearing. (Tr. 214) Baker is also a defendant in a pending federal action brought by Appellant against certain individuals affiliated with the Hospital. (Tr. 196, 219) Furthermore, it was established that another panel member, Dr. Ronald Sowa, is a business partner of a defendant in the pending federal suit and a partner of one of the witnesses who was scheduled to testify against Appellant at the fair hearing. (Tr. 155-156)

Finally, while Appellant had no reason to believe that panel member Dr. Richard Wagner would be biased or otherwise prejudiced, he expressed concern over the fact that Wagner was a family practitioner with no expertise in the area of medicine he was called upon to evaluate. (Tr. 157)

The Appellant also vigorously objected to Mr. William Powell serving as legal advisor to the fair hearing panel. (Tr. 124-138, 167, 192) Prior to the time the present difficulties arose between Appellant and the Hospital in 1978, the Appellant was represented by Mr. Powell in connection with various legal matters. (Tr. 117, 124-25) On February 22, 1980 the Appellant received a letter from Mr. Powell informing him that Powell would no longer represent him personally because of the possibility of a conflict of interest arising due to the fact that Powell represents the Hospital. (Tr. 126) A month later Appellant was informed by Mr. Powell that Powell was representing the Hospital with regard to disciplinary procedures initiated against Appellant. (Tr. 128)

In September 1980, when advised by his attorney that Mr. Powell's representation of the Hospital may not be proper, based on Powell's past association with Appellant, the Appellant formally requested that Mr. Powell withdraw from all participation in these proceedings. (Tr. 130-31) On September

23 1980 Powell informed Appellant's attorney that the firm of Frick and Powell was withdrawing from any and all representation of Deaconess Hospital in connection with any matter affecting R. Anthony Marrese, directly or indirectly, and "we have recommended that Deaconess obtain completely independent counsel for this matter." (Tr. 131, 135-138)

Mr. Powell was also the subject of a complaint filed by the Appellant with the Indiana Supreme Court Disciplinary Commission (Tr. 210) and is named as a Defendant in the pending federal action. (Tr. 197-217) Finally, there was undisputed evidence presented at trial that Mr. Powell had "spread" incorrect information in the community regarding alleged limitations on Appellant's surgical privileges at another Evansville hospital. (Tr. 204).

Despite the fact that Mr. Powell pledged to withdraw from these proceedings because of the existence of a potential conflict and despite the ill-will which exists between Powell and Appellant, Mr. Powell has continued to represent the hospital in this matter. For example, he prepared the notice of hearing and the amended charges furnished to Appellant on May 18, 1983 (Tr. 181) and drafted the procedural guidelines to govern the conduct of the hearing committee. (Tr. 185). Powell went so far as to take responsibility for "the selection of a hearing committee", including the membership and qualifications of the committee. (Tr. p. 170). He has continued to advise the Hospital and the hearing panel with regard to this disciplinary action despite the fact he said he would cease all such representation.

At the trial of this cause, held on July 8, 1983, the Appellees, acting through counsel, informed the Court that Dr. Sowa would be removed from the panel and replaced by Dr. Sam Baker (Tr. 390) who had initially been named as one of the witnesses scheduled to testify against Appellant at the fair hearing set for July 9, 1983. (Tr. 214) In addition, Dr. Baker is

a Defendant in the federal action initiated by Appellant which is still pending on appeal before the Seventh Circuit Court of Appeals. (Tr. 196, 219) Furthermore, there was also evidence presented at the hearing which indicates that Dr. Baker took part in the original decision of the Medical Staff Executive Committee to initiate disciplinary proceedings against Appellant. (Tr. 160) This is demonstrated by the letter of March 8, 1982 written by counsel for the hospital to Dr. Baker. (Tr. 160).

Finally, at the hearing held on July 8, 1983 the Appellees also revealed to the Court that Dr. D. J. Carlson would not testify against the Appellant at the fair hearing, as initially planned. (Tr. 390). His father Dr. Ralph F. Carlson, however, was not removed from the hearing panel.

SUMMARY OF ARGUMENT NOT INCLUDED

Filed
Feb. 10, 1984
Marjorie W. O'Laughlin
Clerk of the
Indiana Supreme and
Court of Appeals

IN THE COURT OF APPEALS OF INDIANA
First District

R. ANTHONY MARRESE,
Appellant-Plaintiff,

v.

DEACONESS HOSPITAL, INC., THOMAS J. RUSCHE, RONALD W. SOWA, RICHARD WAGNER, RALPH F. CARLSON, ROBERT PENKAVA, WILLIAM D. POWELL,
Appellees-Defendants.

Cause No. 1-883-A-247

ORDER

This cause pending before the Court on the following:

1. Appellees' Verified Motion to Dismiss;
2. Appellees' Brief in Support of Motion to Dismiss;
3. Appellant's Memorandum in Opposition to Motion to Dismiss Appeal;
4. Appellees' Reply to Appellant's Memorandum in Opposition to Motion to Dismiss Appeal.

All of which are more particularly in the following words and figures, to-wit:

(H. I.)

And the Court, having examined these matters, having examined the record of the proceedings herein, and being duly advised, now finds that the Appellees' Motion to Dismiss should be granted for the reason that this appeal has become moot.

It is THEREFORE ORDERED that the Appellees' Motion to Dismiss is granted and this cause is dismissed.

ORDERED this 10th day of February, 1984.

/s/ PAUL H. BUCHANAN JR.
Chief Judge

[Seal]

84-1408 (3)

Office - Supreme Court, U.S.
FILED
APR 8 1985
ALEXANDER L. STEVAS
CLERK

NO.

IN THE

SUPREME COURT

OF THE
UNITED STATES

OCTOBER TERM 1984

R. ANTHONY MARRESE, M.D., and BONE AND JOINT SURGEONS, INC.

Petitioner,

v.

INTEROUAL, INC., et al.,

Respondents.

AMICUS CURIAE BRIEF ON BEHALF OF THE UNDERSIGNED STATES IN SUPPORT OF THE PETITION FOR CERTIORARI

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INTEREST OF THE AMICI STATES

The undersigned States are responsible for the enforcement of state and federal antitrust laws and the health care regulatory statutes in this case. As such, the States are interested in an interpretation of those laws that is consistent with the clearly reconcilable legislative purposes of those laws. The decision of the court of appeals below threatens to confuse and undermine the relationship between the federal and state interests in a competitive market for the provision of health care services and the licensing of physicians and hospitals to promote high quality health care services.

SUMMARY OF ARGUMENT

The decision of the court of appeals below is wholly contrary to this Court's clear and repeated articulation and application of the so-called "state action" doctrine. Its insistence on interpreting as irreconcilable the harmonious state policies favoring both competition among health care and other professionals and licensing of those professionals to assure competence undermines the States' ability to carry out those policies.

The court of appeals decision directly conflicts with the opinion of the 4th Circuit in Ratino v. Medical Service of the District of Columbia, 718 F.2d 1260 (4th Cir. 1983), threatening to mislead lower courts and create unnecessary litigation to correct its gross error.

The court of appeals decision misstated and then misapplied the state action doctrine. Its finding of a "clear articulation" of state policy in the existence of a state peer review statute ignores the need to determine whether the statute reveals a legislative intent to "displace competition" with regulation of physician services. Further, its finding of "active state supervision" in the mere existence of state physician and hospital licensing laws fails to meet this Court's requirement that a state provide for a "pointed reexamination" of the private conduct being challenged. These errors make review by this Court crucial to avoid further confusion.

The court of appeals affirmance of the dismissal of plaintiff's antitrust suit on the pleadings on a ground not considered by the district court is

unprecedented in this Court's state action cases. To find state action immunity in a case such as this involving purely private conduct alleged to be in "bad faith" and therefore outside of any alleged state statutory duty requires at least a cursory factual examination. Absent such an examination, the lower courts cannot fairly determine the crucial questions of whether the alleged conduct falls within a "clearly articulated" and "affirmatively expressed" state policy to displace competition and whether the private conduct was "actively supervised" by the state. The court of appeals decision thus offers a broad protective umbrella for even the most blatant anticompetitive conduct that is ostensibly conducted pursuant to state peer review and licensing laws. This result is contrary

to this Court's decisions and the federal and state policies favoring competition generally and among health care providers in particular.

ARGUMENT

I. THE DECISION OF THE COURT OF APPEALS CONFLICTS IRRECONCILABLY WITH A DECISION OF ANOTHER COURT OF APPEALS REGARDING THE RELATIONSHIP BETWEEN THE ANTITRUST LAWS AND STATE REGULATION OF PHYSICIANS AND HOSPITALS

The court of appeals below held that the voluntary activities of private physicians and a private hospital were exempt from the federal antitrust laws because of the claimed existence of state laws that purportedly meet the requirements of this Court's "state action" doctrine. See, Parker v. Brown, 317 U.S. 341 (1943); Southern Motor Carriers Rate Conference, Inc. v. U.S., ____ U.S. ____ (March 27, 1985); Hoover v. Ronwin, _____ U.S. _____, 104 S.Ct. 1989 (1984). This decision is in direct conflict with that of the Court of Appeals for the Fourth Circuit in Ratino v. Medical Service of the District of

Columbia, 718 F.2d 1260 (4th Cir. 1983). The court of appeals decision below intolerably confuses the meaning and scope of the state action doctrine, and threatens to lead other federal and state courts[1] to provide an unjustified immunity for a wide range of private conduct in the health care industry.

In Ratino, the court of appeals rejected the contention that a Maryland statute creating a physician disciplinary commission provided the requisite clear articulation of a state policy to displace competition with actively state supervised regulation of the challenged conduct necessary to meet the test enunciated by the Parker case and its

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1 See, e.g., RCW 19.86.920 (1983) which directs Washington state courts to "be guided by final decisions of the federal courts . . . interpreting the various statutes dealing with the same or similar matters . . ."

progeny. 718 F.2d at 1268.[2] The court of appeals stated that Maryland's regulatory scheme which, inter alia, authorized a state board to discipline physicians for gross and willful overcharging did not evidence a state policy to displace price competition for physician services in Maryland.

In the instant case, the court of appeals affirmed the dismissal on the pleadings of an antitrust suit alleging a conspiracy among private physicians at a private hospital to boycott the plaintiff by revoking the plaintiff's privileges at the hospital. Stripped of its confused rhetoric, the court below held that the existence of two facts -- 1) the state requires private hospitals to establish peer review committees and 2) that state

2 At issue in Ratino was a physician reimbursement practice of a private third-party payor of health care services.

physician and hospital licensing boards may gain access to information adduced by such committees -- shielded the challenged conduct from antitrust scrutiny under the state action doctrine. Op. at 21-35.[3]

This conflict stems from the 7th Circuit's complete misreading of this Court's cases articulating the requirements of and rationale underlying the state action doctrine. This Court has repeatedly emphasized that private parties may only claim the cloak of state

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3 The statutory availability of peer review materials to physician licensing boards more likely evidences a state purpose to avoid claims of confidentiality rather than "supervision" of private conduct. See, e.g., Medical Peer Review Protection in the Health Care Industry, 52 Temple L.Q. 552 (1979) and cases discussed therein. As discussed further in Part III, infra, this ambiguity of state policy is another reason why summary dismissal is wholly inappropriate in this case.

action when the state, acting through its legislature or supreme court, has:

1) "clearly articulated" and "affirmatively expressed" a policy to "displace competition" with regulation, Southern Motor Carriers, supra, slip op. at 8, 13; and

2) provided for active state supervision of the private conduct, Southern Motor Carriers, supra.

The implications of the court of appeals decision are staggering. The opinion arguably immunizes any conduct by private physicians which can be claimed to be within a "peer review" context. The mere permissive authority for the consideration of peer review materials by a physician licensing board -- but not reexamination of a private hospital's privilege revocation decision -- cannot be read to provide a clear articulation

of an anticompetitive state policy or the requisite active supervision. Of course, every state requires both physicians and hospitals to be licensed under state law in a manner similar to the Indiana statute under consideration in this case. This unjustifiable expansion of state action immunity might prevent challenges to even the most blatant anticompetitive activities by purely private parties, so long as the conduct was supposedly performed within the context of a hospital governing structure. Such a result would be contrary to the clear rulings of the Court, that of the 4th Circuit in Ratino, congressional intent and the intent of state legislatures, and should not be allowed to stand.

II. THE COURT OF APPEALS INCORRECTLY CONSTRUED BOTH FEDERAL AND STATE LAW IN FINDING THAT PURELY VOLUNTARY AND ALLEGEDLY CONSPIRATORIAL CONDUCT OF PRIVATE PARTIES IS IMMUNE FROM ANTITRUST SCRUTINY BECAUSE OF THE SUPPOSED CONFLICT BETWEEN ANTITRUST LAW AND STATE STATUTES AUTHORIZING PEER REVIEW OF PHYSICIANS AND REQUIRING THE LICENSURE OF PHYSICIANS AND HOSPITALS.

A. State Action Immunity Requires Proof that the Challenged Conduct is Within a "Clearly Articulated" and "Affirmatively Expressed" State Policy to Displace Competition with Regulation

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This Court has repeatedly made clear that exemptions from the antitrust laws are disfavored and are not to be lightly implied and, if found, must be contrued as narrowly as possible. See, e.g., Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119 (1982) (peer review activities by private health care providers not exempt as "business of insurance" within the meaning of the McCarran-Ferguson Act); National Gerimedical Hospital v. Blue Cross, 452 U.S. 378 (1981)

(voluntary "cost containment" by private parties not impliedly exempt due to provisions of the National Health Planning and Resources Development Act).

In applying this principle to claims of immunity because of supposed "state action," the Court has articulated a "two-pronged test" that must be met before a private party[4] can claim the shield of a state-granted immunity. First, the state must "clearly

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4 Although the Court said in Southern Motor Carriers that the "success of an antitrust action should depend upon the nature of the activity challenged, rather than on the identity of the defendant," slip op. at 10, other recent decisions of the Court make clear that acts by the state itself or by municipalities are subject to less stringent tests. Hoover v. Ronwin, ____ U.S. ____, 104 S.Ct. 1989 (1984) (actions by state supreme court or state legislature exempt without further analysis); Town of Hallie v. City of Eau Claire, ____ U.S. ____, (March 27, 1985) (no active state supervision of conduct by municipalities required for state action immunity to attach).

articulate" and "affirmatively express" a policy to displace competition in a specific area of commerce with a scheme of regulation. Southern Motor Carriers Rate Conference, Inc. v. U.S., ____ U.S. ____ (March 27, 1985). As part of this requirement, it must be clear that the specific, private "anticompetitive conduct of the State's representative was contemplated by the State." Hoover v. Ronwin, ____ U.S. ____, 104 S.Ct. 1989, 1995 (1984). Second, the private conduct must be "actively supervised" by the state itself. California Liquor Dealers v. Midcal Aluminum, 445 U.S. 97 (1980). This element flows from the principle that a state may not "give immunity to those who violate the Sherman Act merely by authorizing them to violate it." Parker v. Brown, 317 U.S. 341, 351 (1943).

Rather,

> This active supervision requirement ensures that a state's actions will immunize the anticompetitive conduct of private parties only when the "state has demonstrated its commitment to a program through its exercise of regulatory oversight."

Southern Motor Carriers, supra, fn. 23.

The application of these principles to the case at bar shows that the regulatory statutes at issue do not form the basis as a matter of law at the pleadings stage for the immunization of purely private, voluntary conduct. Far from being the clear articulation and affirmative expreession of state policy that the Court has required, the Indiana laws supposedly offering the cloak of state protection in this case are statutes of general application that in no way conflict with the preeminent

federal policy favoring free competition.

States pass both peer review and licensing laws to assure competent, ethical performance of essential health care services.[5] Absent an affirmative expression of state policy, there is no reason to assume that a peer review statute is meant to be used as a means to exclude competent, but "undesirable" physicians[6] from a hospital medical

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5 This Court has discarded the argument that competition is inconsistent with the nature of the licensed professions. National Society of Professional Engineers v. U.S., 435 U.S. 679 (1976). Similarly, the Court has found competition and the antitrust law to be consistent with both federal and state policies aimed at assuring high quality, low cost health care services, Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982); National Gerimedical Hospital v. Blue Cross, 452 U.S. 378 (1981). Thus, there is no basis for holding that physicians or hospitals should be subject to a broader grant of state action immunity than other businesses.

6 E.g., doctors who offer "undesirable" competition to

staff. Thus, it was incorrect for the court of appeals below to decide that Indiana has clearly articulated through its peer review law a state policy to "displace competition" as required by this Court's decisions.

B. "Active State Supervision" -- Which Consists of a "Pointed Re-examination" of Private Conduct -- Is Also Required for State Action Immunity to Attach

Further, the mere existence of a licensing board which "may" consider peer review materials but has absolutely no authority to review private hospitals' individual staffing decisions does not at all constitute the "pointed re-examination" of private conduct required for a finding of "active state supervision." In Midcal, the Court rejected a claim of immunity which had

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physicians who control or influence the peer review process.

been based on a state wine "price posting" law. The Court found that

> The State neither establishes prices nor reviews the reasonableness of the price schedules; nor does it regulate the terms of fair trade contracts. The State does not monitor market conditions or engage in any 'pointed reexamination' of the program. The national policy in favor of competition cannot be thwarted by casting such a gauzy cloak of state involvement over what is essentially a private price-fixing arrangement.

California Liquor Dealers v. Midcal Aluminum, 445 U.S. 97, 105-106 (1980) (footnote ommitted). Cf. Cantor v. Detroit Edison, 428 U.S. 579 (1976) ("no antitrust immunity was conferred when a state agency passively accepted a public utility's tariff", Cantor as interpreted in Midcal, 445 U.S. at 104) with New Motor Vehicle Board v. Orrin Fox, 439 U.S. 96 (1978) (immunity found where state board held thorough hearings to

review private conduct undertaken pursuant to a clearly articulated state policy).

In its recent Southern Motor Carriers decision, the Court reemphasized the importance of this prong of the Midcal test. A state must "demonstrate[] its commitment to a program through its exercise of regulatory oversight" for state action immunity to apply. Southern Motor Carriers, supra, slip op. at fn. 23.

Only the most strained interpretation of the hospital and physician licensing statutes at issue in the instant case can find "active state supervision" of private peer review conduct. Assuming for the sake of argument that the peer review statute did evidence a "clearly articulated" and "affirmatively expressed" policy to

displace competition among physicians with state regulation, there is no "commitment to a program" demonstrated by an "exercise of regulatory oversight." Indeed, the physicians and hospital licensing boards which the court of appeals held to have provided the requisite state supervision are not even authorized, let alone required, to review private hospitals' medical staffing decisions. A finding of state action based on this evidence of active state supervision would approve just the type of "gauzy cloak of state involvement" which the Court has held insufficient.

III. THE APPLICATION OF THE STATE ACTION DOCTRINE TO PRIVATE PARTIES NECESSARILY REQUIRES AT LEAST A CURSORY EXAMINATION OF THE FACTS ALLEGED IN THE COMPLAINT TO DETERMINE WHETHER THE ALLEGED CONDUCT FALLS WITHIN THE SCOPE OF A STATUTE WHICH PURPORTEDLY ESTABLISHES ANTITRUST IMMUNITY.

One of the gravest dangers of the court of appeals decision in this case is its refusal to allow even a limited examination by the trial court of the facts alleged by the plaintiff to be in violation of the antitrust laws. This result threatens to create a broad protective umbrella which could shield even the most blatant and anticompetitive conspiracies performed under the guise of hospital governance.

As amici states, we have no view on the merits of Dr. Marrese's complaint, and it is not necessary that the Court form a judgment on this question either. However, for the purpose of reviewing the affirmance of the granting of a motion to

dismiss, we must assume the facts alleged in the complaint are true. Dr. Marrese alleges a conspiracy by a group of competing physicians to abuse, in bad faith, positions of influence in the only hospital in Evansville, Indiana by recommending the revocation of Dr. Marrese's hospital privileges in order to eliminate him as a competitor. Numerous antitrust suits have been filed in recent years alleging similar conspiracies without a single successful claim of state action immunity. See, e.g., Robinson v. Magovern, 521 F.Supp. 842 (W.D. Pa. 1981), aff'd, 688 F.2d 824 (3d Cir. 1982); Smith v. Northern Michigan Hospitals, 703 F.2d 942 (6th Cir. 1983); Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346 (7th Cir. 1982). This Court has made clear that unreasonably

anticompetitive conduct in a hospital setting would violate the antitrust laws. Cf. Jefferson Parish Hospital Dist. v. Hyde, 434 U.S. 1011 (1984) (exclusive contract between hospital and group of anesthesiologists might be unlawful if sufficient market power shown).

Never before has this Court allowed the dismissal under the state action doctrine of an antitrust complaint charging such a conspiracy among purely private parties. Indeed, all of the cases cited by the court of appeals in support of its proposition that such an early dismissal is warranted are decisions involving actions by the state itself, by a state agency, or by private parties alleged to be in combination with state officials. See, Hoover v. Ronwin, _____ U.S. _____, 104 S.Ct. 1989 (1984)

(bar examination rules exempt as actions of the state supreme court); Gambrel v. Kentucky Board of Dentistry, 689 F.2d 612 (6th Cir. 1982), cert. denied, 103 S.Ct. 1198 (1983) (conduct compelled by state law undertaken by private dentists allegedly acting in concert with state officials exempt on summary judgment); Benson v. Arizona State Bd. of Dental Examiners, 673 F.2d 272 (9th Cir. 1982) (regulation of nonresident dentists exempt as action of state board).

This distinction is crucial, as this Court recently recognized in allowing the dismissal at the pleadings stage of a complaint charging a state committee of bar examiners -- itself an arm of the state supreme court -- with antitrust violations:

> Closer analysis is required when the activity at issue is

> not directly that of the legislature or supreme court, but is carried out by others pursuant to state authorization . . . In such cases, it becomes important to ensure that the anticompetitive conduct of the State's representative was contemplated by the State.

Hoover, supra, at 1995 (footnote and citations omitted). Cf. Southern Motor Carriers Rate Conference, Inc. v. U.S., ___ U.S. ____ (March 27, 1985) (conduct of private parties held exempt on summary judgment on a stipulated factual record.)

With the exception of the court of appeals in the instant case, the lower courts have not had trouble understanding this principle. In several health care cases, courts of appeals have reversed precipitous dismissals in order to require the district court to examine the factual basis for the claim of state action immunity. E.g., Virginia Academy

of Clinical Psychologists v. Blue Shield of Virginia, 624 F.2d 476 (4th Cir. 1980) cert. denied, 450 U.S. 916 (1981); Feminist Women's Health Center v. Mohammad, 586 F.2d 530, 550 (5th Cir. 1978) cert. denied, 444 U.S. 924 (1980). The need to examine the underlying evidence is especially important in a case like the one before the Court, where the complaint alleges a conspiracy involving "bad faith" conduct outside the scope of the duties of a private party acting in a quasi-official capacity.[7]

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7 This analysis may well reveal no disputed issues of fact, in which case summary judgment would, of course, be appropriate. Southern Motor Carriers, supra; Orrin W. Fox Co. v. New Motor Veh. Bd., 440 F.Supp. 436 (C.D. Cal. 1977), aff'd sub nom. New Motor Veh. Bd. v. Orrin W. Fox Co., 439 U.S. 96 (1978). The amici states intimate no view on whether summary judgment would be appropriate in the instant case.

The court of appeals' refusal even to address the fact that the plaintiff's complaint alleged conduct outside the protection of even a broad reading of the state statutes in question reveals just how far the decision reaches. Dr. Marrese expressly alleged that the conspiracy was in bad faith and thus not protected by a general civil damages immunity provision of state law. Amended Complaint para. 49. While Dr. Marrese may ultimately be unsuccessful in proving his allegations, the district court must at least determine whether an issue of fact exists before assuming that the conduct is protected by the state action doctrine. Thus, the court of appeals decision prohibits Dr. Marrese's suit even if the alleged conduct was done solely for anticompetitive reasons outside of any alleged expression of

state policy.[8] This result is contrary to this Court's decisions and is unprecedented even among lower court decisions.

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8 It is significant to note that the district court dismissed the complaint for lack of an effect on interstate commerce, a ground rejected by the court of appeals. The district court did not itself address the question of state action. Thus, the parties had no opoortunity at all to present evidence on these crucial questions.

CONCLUSION

For the reasons discussed herein, the Court should grant the plaintiff's Petition for Writ of Certiorari.

Dated: April 5, 1985.

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No. 84-1406 (4)

FILED
APR 24 1985
ALEXANDER L. STEVAS,
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

R. ANTHONY MARRESE, M.D., and BONE AND JOINT SURGEONS, INC.,

Petitioners,

v.

INTERQUAL, INC., et al.,

Respondents.

SUPPLEMENTAL BRIEF OF PETITIONERS

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SUPPLEMENTAL BRIEF OF PETITIONERS

Pursuant to Rule 35.5 of the Rules of Practice of this Court, Petitioners, R. ANTHONY MARRESE and BONE AND JOINT SURGEONS, INC., hereby respectfully discuss the appropriateness of reviewing the Seventh Circuit's decision in the instant case in light of this Court's recent decisions in *Town of Hallie* v. *City of Eau Claire,* ____ S.Ct. ____, 82-1832 (March 27, 1985) 48 A.T.T.R. 570 (BNA), and *Southern Motor Carriers Rate Conference, Inc.* v. *United States,* ____ S.Ct.____, 82-1922 (March 27, 1985) 48 A.T.T.R. 574 (BNA).

The first issue presented is the degree of clarity with which a state legislature must articulate its intent to displace competition with regulation. *Town of Hallie* holds that the state legislature need not specifically state that it intends anticompetitive conduct to result from application of state policy; it is sufficient that such conduct "is a foreseeable result" of engaging in the authorized activity. 48 A.T.T.R. at 572. In that case, the state legislature was clear in its delegation of authority to the *City of Eau Claire* to provide or withhold sewage treatment and other related services. Wis. Stat. Ann. § 66.096(2)(c) (Supp. 1984). Cases involving such absolute grants of discretion will be easily resolved under this standard. But other courts, lacking appropriate guidelines, will remain free to engage in unwarranted speculation as to what the legislature could reasonably have foreseen at the time of enactment of its statute and, more importantly, what sorts of conduct may objectively be viewed as "foreseeable" in the context of legislative pronouncements.

The Seventh Circuit, in the case at bar, applied a subtly yet radically different test. It found that a hospital staff's review of medical treatment and surgical procedures of a competing doctor was a "necessary *and* reasonable consequence" of implementing the states policy favoring peer review, *Marrese* v. *Inter Qual,* (App. 30). But the peer review process itself is not challenged by the petitioners. It is the perversion of this process to serve the competitive positions of certain of the defendants which is being challenged.

The fundamental flaw in the Seventh Circuit's analysis was that peer review can be accomplished without a violation of the antitrust laws.

It is this simplistic approach to the implementation of the state action doctrine which causes the Seventh Circuit's opinion in this case to conflict with this court's decisions and the decisions of the Second and Sixth Circuits in framing the

appropriate inquiry. See *Capital Telephone Co.* v. *New York Telephone Co.*, No. 84-7176 (2d Cir. Dec. 18, 1984); *Hybud Equipment Corp.* v. *City of Akron*, 742 F.2d 949 (6th Cir. 1984), *cert. denied*, (April 1, 1985) 48 A.T.T.R. 622 (BNA).

In *Hybud Equipment Corp.*, the court found that the challenged activities themselves were "necessary and reasonable" consequences of engaging in the authorized activity. *Id.* at 962. The Seventh Circuit, on the other hand, distorted this test beyond logical application by deciding that simply because an occasional recommendation of staff privilege revocation is a reasonable consequence of engaging in legislatively authorized peer review, any and all motivations and activities leading to such a recommendation by a peer review committee are beyond antitrust inquiry. This reasoning has the absurd effect of immunizing anticompetitive behavior which the Indiana legislature not only *foresaw*, but *expressly guarded against* by excluding from state court immunity peer review activities undertaken in bad faith. Ind. Code § 34-4-12.6-3.

Unlike *Town of Hallie* or *Southern Motor Carriers*, the legislative scheme at issue here does not encompass any grant of absolute discretion in exercising *delegated* authority. On the contrary, the Indiana legislature merely authorized hospitals to exercise authority they possess independent of the legislature. The Indiana legislature simply has not authorized peer review committees to engage in anticompetitive activities. A reasonable exercise of delegated discretion such as that involved in *Hybud Equipment Corp.* differs substantially from the situation here presented in the parameters set by the legislature.

Though this Court has not explicated this "foreseeability" standard in any detail, it seems intuitive that foreseeability must be evaluated in the context of the legislative pronouncement in question and that the appropriate focus of the evaluation must be the precise conduct that is challenged. In *Southern Motor Carriers*, this Court stated that Petitioners' conduct would be

entitled to *Parker* immunity only if their challenged activity —collective ratemaking—was clearly sanctioned by the legislature. *Southern Motor Carriers Rate Conference, Inc.* v. *United States,* 48 A.T.T.R. at 578. By analogy, the conduct claimed to be immune from antitrust scrutiny should, at the very least, be demonstrated to have been foreseen and implicitly approved by the legislature.

The question of whether the legislature must at least "foresee" the specific alleged anticompetitive conduct before that conduct will be immunized from antitrust examination is one left open by the Court's recent decisions. Examination of this issue in the instant case will surely help to resolve the conflict this doctrine has engendered by ensuring that only true state action escapes antitrust liability.

The second issue presented in this case is the extent of state supervision required in order to qualify for immunity under other prong of the test enunciated in *California Retail Liquor Dealers Assn.* v. *Midcal Aluminum, Inc.,* 445 U.S. 97 (1980); active state supervision of the regulatory program in question. The Court in *Town of Hallie* held that this second prong of the *Midcal* test is inapplicable to municipalities. 48 A.T.T.R. at 573. The respondents in *Southern Motor Carriers,* moreover, conceded the presence of sufficient active state supervision; thus the Court in finding *Parker* immunity did not analyze this issue. By finding that adequate "active state supervision" exists when no state agency has the authority to affect the ultimate actions of a peer review committee, the Seventh Circuit has added a dimension of unbelievable confusion to the *Parker* doctrine. Reversal of the Seventh Circuit's decision and clarification of the "active state supervision" doctrine are essential and will provide the finishing touch to the doctrines as developed by this court in *Midcal Aluminum Inc.* As discussed in the Petition for Certiorari, disagreements abounds regarding the minimum level of "active" involvement by the state in order to immunize

regulatory programs with anticompetitive effects. The Seventh Circuit's unprecedented approach to this troublesome question, if allowed to stand, will serve only as an obstacle to complete understanding of the state action immunity doctrine.

Respectfully submitted,

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FILED
MAY 25 1985
ALEXANDER L. STEVAS, CLERK

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Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR RESPONDENTS IN OPPOSITION

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QUESTIONS PRESENTED

1. Did the Seventh Circuit Court of Appeals establish any new standards for the determination of state action immunity from the federal antitrust laws?

2. Did the Seventh Circuit Court of Appeals establish any conflict among the circuits as to the standards to be applied in determining whether a state's program qualifies for state action immunity from the federal antitrust laws.

3. Does Indiana's statutory program governing hospitals and physicians which requires hospitals and their medical staffs to conduct peer review concerning the quality and necessity of medical care, provides for absolute immunity from civil liability for good faith participants in such review and supervises its implementation through both administrative regulation and judicial proceedings qualify for exemption from the federal antitrust laws under the state action immunity doctrine?

ADDITIONAL STATUTES AND REGULATIONS INVOLVED

Ind. Code §§ 16-10-1-7; Ind. Code § 16-10-1-9; Ind. Code § 16-10-1-12; Ind. Code § 16-10-1-13; Ind. Code § 16-10-1-14; Ind. Code § 16-10-17; 410 Ind. Adm. Code 15-1-1; 410 Ind. Adm. Code 15-1-2; 410 Ind. Adm. Code 15-1-5; 410 Ind. Adm. Code 15-1-7; 410 Ind. Adm. Code 15-1-8 and §44 Ind. Adm. Code 4-6-1 to 4-6-10.

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BRIEF FOR RESPONDENTS IN OPPOSITION

SUPPLEMENTAL STATEMENT OF THE CASE

This case involves a challenge under Federal Anti Trust Laws to revocation of Petitioner's privileges at Deaconess Hospital. The revocation occured after a peer review hearing held pursuant to a Fair Hearing Plan required by the State of Indiana.

The Petitioners originally filed this lawsuit in the summer of 1982. The complaint alleged violations of the Sherman Antitrust Act and requested an injunction against the Respondents barring them from proceeding with the "fair hearing proceeding" which was then pending. Respondents questioned *inter alia* whether the state action exemption applied to this case. The District Court dismissed Petitioner's lawsuit in February of 1983 on jurisdictional grounds, and did not reach the state action exemption issue. During the pendency of the

matter in the Seventh Circuit Court of Appeals, supplemental briefs were requested by the court on the state action exemption issue for medical staff peer review. Such briefs were filed, and the court issued its decision in November of 1984.

During the pendency of the matter in the District Court, the peer review hearing did not proceed. The matter was set for a hearing on the plaintiff's medical staff privileges after the case was dismissed.

There is substantial material in the petition and appendix which is outside the record. The actual record before the court consists of the pleadings and rulings thereon. The Complaint alleges that Dr. Marrese is an orthopedic surgeon who was practicing alone as Bone and Joint Surgeons, Inc. in Evansville, Indiana. When the matter was originally filed, he had surgical privileges at Deaconess Hospital, one of the hospitals in that community. The hospital had adopted a "Fair Hearing Plan" which provided procedures for hearing and decision regarding the nature and extent of hospital staff privileges for any physician whose privileges came into question. The complaint further alleges that the "peer review committee" established thereunder was authorized pursuant to Indiana Statute. Dr. Marrese filed suit in the District Court naming the participants in the peer review process as defendants. These included those persons who had previously been designated as prospective members of the peer review committee as well as members of the Board of Directors of the hospital, the administrator of the hospital, the attorney for the hospital and an outside medical audit company.

Prior to the hearing scheduled before the peer review committee, but subsequent to the dismissal of this case by the District Court, Dr. Marrese filed a verified complaint for injunction in the Vandenburgh Circuit Court of the State of Indiana, Cause No. 9454, challenging the peer review proceeding, the composition of the review panel and the good faith of the participants in the peer review procedure.

Dr. Marrese was offered an alternative panel of physicians associated with Indiana University Medical School and completely outside of Deaconess Hospital (and indeed Evansville, Indiana) for his peer review panel which he declined. He raised objections to a specific panel member at the time of hearing on his complaint for preliminary injunction, and that panel member was voluntarily withdrawn by the hospital. An evidentiary hearing was held before Judge William H. Miller, regular judge of the Vandenburgh Circuit Court on July 8, 1983. At the conclusion of that hearing Judge Miller made the following ruling:

> "Let the record show that the court finds that Peer Review Statute covers this procedure that the petitioner attacked, petitioner being the plaintiff and now finds the plaintiff having failed to prove malice on the part of the amended panel, the court now OVERRULES plaintiff's Motion For Temporary Restraining Order, Preliminary Injunction." (Transcript of hearing, pages 113-114)

As acknowledged in Petitioner's Appendix, he unsuccessfully appealed that order to both the Indiana Court of Appeals and the Supreme Court of the State of Indiana.

After the State Court denied Dr. Marrese's request for an injunction, the peer review committee met for two days and heard over 600 pages of testimony. The parties were represented by counsel and were granted the right to voir dire of the members of the panel, all of whom were physicians on the medical staff of Deaconess Hospital. After voir dire, Mr. Sharpe, counsel for Dr. Marrese, made the following statement on the record:

> "Mr. Powell, we have no objections to the members of the Hearing Panel, we think they are taking their position here quite seriously and it seems to us that they are going to make an effort to give an objective hearing today." (Transcript of Fair Hearing, Pg 15)

In addition to being given the right of voir dire, the parties had opportunity to present evidence and cross examine opposing witnesses as well as the right to make opening and closing statements. Subsequent to the hearing, the panel made and presented written findings which included a recommendation that Dr. Marrese's staff privileges be terminated. An appeal was taken to the hospital's Board of Directors which ratified the action of the hospital's peer review committee.

Respondents readily concede that much of this is outside of the record before this Court-as is much of Petitioners' statement of the nature of this case. It is brought to the court's attention because the Respondents believe that the Petitioner's version of the events which have occurred is substantially misleading and incomplete.

NATURE OF THE CASE

This petition is before this court on the limited issue of whether the Indiana statutory and regulatory program exempts medical staff peer review proceedings from federal antitrust laws. The Indiana Code contains three titles enacted by the legislature which apply to this situation. Title 16 of the Indiana Code deals with Health and Hospitals, Title 25 deals with Medical Licensing, and Title 34 contains Special Provisions Relative to Peer Review. Indiana has also published regulations adopted pursuant to Statute in the Indiana Administrative Code.

I.
INDIANA STATUTORY AND REGULATORY SCHEME

A. SUMMARY OF INDIANA LEGISLATIVE STRUCTURE

Under Indiana law, a hospital and its medical staff are required to engage in medical quality peer review. Specific statutory provisions set forth the parameters of peer review and

minimum requirements for its implementation. All physicians are required to have their hospital privileges reviewed at least every 2 years, and a hospital is required to immediately report any non-compliance with the statutory requirements which include peer review. A Hospital Licensing Council is empowered to suspend or revoke a hospital's license, or, in the alternative, allow it to continue operating temporarily if that does not injure patient health, safety and welfare. Hospitals are required to be inspected regularly, and hospital licenses are renewed annually.

The Indiana legislature provided for immunities for those engaged in peer review. The State of Indiana has clearly determined that peer review is necessary and required. It has further determined that it should be initiated by hospitals and their medical staffs who are in a position to have both the knowledge and expertise to intervene to protect the public health, safety and welfare. Broad immunities have been granted to ensure the willingness of the participants to engage in a review of another physician's standards of practice. Limited judicial review is provided under standards set by the Indiana legislature.

B. HOSPITAL LICENSING

Hospitals are licensed and regulated by the Indiana State Board of Health. Indiana Code § 16-10-1-1 through § 16-10-1-19. The State Board of Health administers the hospital licensing statute with the advice and consent of a Council created pursuant to statute. Ind. Code § 16-10-1-3 and § 16-10-1-4. The Hospital Council consists of 8 members appointed by the state's governor. The governor is directed to appoint a physician, a registered nurse, four hospital administrators and two additional members from the State Department of Public Welfare and the State Board of Health. Ind. Code § 16-10-1-3.

The legislature defines a hospital for purposes of state regulation in Indiana Code § 16-10-1-6. The plaintiff alleges,

and there is no dispute, that Deaconess Hospital is a hospital pursuant to statute.

Hospitals are required to have a Governing Board which is statutorily defined and granted the following authority:

> "(a) The governing board of the hospital shall be the supreme authority in the hospital responsible for the management, operation, functioning, and control of the hospital, and the appointment of the members of the medical staff and the assignment of privileges to members of the medical staff with the advice and recommendations of the medical staff consistent with their individual training, experience and other qualifications.
>
> (b) The governing board shall report, in writing, to the Indiana medical licensing board, the results and circumstances of any final, substantive, and adverse disciplinary action taken by the governing board regarding a physician on the medical staff, or an applicant for the medical staff, if the action results in voluntary or involuntary resignation, termination, nonappointment, revocation, or significant reduction of clinical privileges or staff membership. . . .The governing board and its employees, agents, consultants and attorneys have absolute immunity from civil liability for communications, discussions, actions taken, and reports made concerning disciplinary action or investigation taken or contemplated, if such reports or actions are made in good faith and without malice." Ind. Code § 16-10-1-6.5.

The same statutory provision provides for certain responsibilities of the medical staff as follows:

> "(c) The medical staff of a hospital shall be an organized group which shall be responsible to the governing board for the clinical and scientific work of the hospital, advice regarding professional matters and policies to the governing board, and shall have the responsibility of reviewing the professional practices in the hospital for the purpose of reducing morbidity and mortality, and for the improvement of the care of patients in the hospital. This review shall include, but shall not be limited to, the quality and

necessity of the care provided patients and the preventability of complications and deaths occurring in the hospital.

(d) The members of any medical staff committee organized for the purpose of conducting medical review, being retrospective and not a part of current patient care, shall have an absolute immunity from civil liability for communications made in committee meetings, and reports and recommendations made by the committee arising from deliberations by the committee to the governing board of the hospital or another duly authorized medical staff committee." Ind. Code § 16-10-1-6.5.

Hospitals in Indiana are required to be licensed. Indiana Code § 16-10-1-7. Application for a license is submitted to the Hospital Council which is granted authority to conduct investigations and hold hearings. Licenses, when granted, are issued for a period of one year and are subject to annual renewal. Ind. Code § 16-10-1-9. The State Board of Health is granted authority to suspend or revoke a hospital license pursuant to the terms of Ind. Code § 16-10-1-10. The grounds set forth in the statute include violation of any provision of the chapter relating to licensing or any rule or regulation issued thereunder. Grounds for revocation or suspension can also include conduct or practice found by the Council to be detrimental to the welfare of the patients in such institution. The Council is granted authority to adopt rules and regulations as are necessary in the public interest. Ind. Code § 16-10-1-12. The State Board of Health is required to periodically inspect any hospital licensed in the State of Indiana pursuant to the statutes and rules and regulations adopted and approved by the Council and the Board. Ind. Codes §§ 16-10-1-13 and 16-10-1-14.

A number of regulations have been adopted by the Indiana State Board of Health pursuant to its statutory authorization. The regulations relevant to hospital operation and management are found primarily at 410 Ind. Adm. Code (IAC) § 15-1-1 through § 15-1-23. Hospitals, as a condition for maintaining their license, are required to comply with all regulations. 410 IAC 15-1-2. In addition, if a situation arises

which prevents a hospital from complying with any regulation, the hospital is required to report that to the Hospital Licensing Council. The Council may, under those circumstances, permit the hospital to continue operation for a specified period of time if compliance is not immediately possible and the safety and well being of patients will not be jeopardized. 410 IAC 15-1-2.

The hospital governing board is required to file an annual application for licensing. It is required to adopt by-laws by which the hospital will function. It is also required to approve by-laws, rules and regulations of the medical staff and audit procedures or other measures used to assure quality of care. The hospital governing board has the responsibility to appoint members to the medical staff and assign them privileges. The assignment is not permanent but is granted on a periodic basis with renewal terms not to exceed two years. Privileges are granted with the advice and recommendations of the medical staff. 410 IAC 15-1-5.

The medical staff is required to initiate, adopt and amend by-laws, rules, regulations and policies including those relating to qualifications for appointment to staff membership and for deliniation of privileges. 410 IAC 15-1-7(2). These rules are to be submitted to the governing body of the hospital for approval. The medical staff is specifically required to include provisions for:

> "(d) Establishment of mechanism to carry out Medical Staff functions either by the staff as a whole or by designated committees in the following areas:
>
> (1) Review of applications for staff membership, deliniation of privileges, and recommendation on appointment to the Governing Body.
>
> (2) Appeal of decisions regarding Medical Staff membership and privileges.
>
> (3) Review and analysis, at regular stated intervals, of clinical performance, pathological reports, the completeness of medical records and the enforcement of requirements related thereto, of infection control, of use of blood and blood related elements, and of total patient care." 410 IAC 15-1-7(2)(d).

The hospital is specifically required to maintain a number of records for inspection (and forwarding if requested) by the Hospital Licensing Council and the State Board of Health. These records include the constitution, by-laws, rules and regulations of the Governing Body and Medical Staff; the minutes of meetings of the Governing Body, the Medical Staff and committees thereof and the privileges of all members of the Medical Staff. 410 IAC 15-1-8.

C. MEDICAL LICENSING

The legislature created a Medical Licensing Board to govern and regulate the conduct of physicians. Ind. Code § 25-22.5-2-1 *et seq.* The governor appoints 7 persons who make up the Medical Licensing Board consisting of 5 physicians, an osteopathic physician and a member of the general public. The Medical Licensing Board meets a minimum of two times each year and more often if necessary. A service bureau is established to keep records, including applications, licenses and permits. Ind. Code § 25-22.5-2-2.

The legislature has set forth statutory requirements for the licensing of physicians as well as guidelines on the examinations administered to applicants. Ind. Code §§ 25-22.5-3-1 and 25-22.5-4-1.

The legislature also granted the Board the power to promulgate rules and regulations relating to medical licensing. Ind. Code § 25-22.5-2-7. The Medical Licensing Board is granted the power to enforce all provisions of the Indiana Medical Licensing Statute and also assign the service bureau duties necessary for the enforcement of the statute. Ind. Code § 25-22.5-2-7.

A licensed physician in Indiana must conduct his practice in accordance with the standards established by Medical Licensing Board. Ind. Code § 25-22.5-6-2.1(b). The Indiana legislature has provided for the method of initiating potential

sanctions against a physician. Any person who initiates or participates in any proceedings for sanctions is immune from civil liability. Ind. Code § 25-22.5-6-3. The Medical Licensing Board receives required reports from hospitals regarding adverse disciplinary actions taken against any of their staff physicians. Ind. Code 25-22.5-6-3 and 16-10-1-6.5. The Licensing Board's actions are, thereafter, independent of any proceedings previously taken by a hospital staff pursuant to the required peer review procedures.

D. PEER REVIEW

The Indiana legislature has further codified requirements, standards and procedures for peer review committees under Chapter 12.6 Title 34 of the Indiana Code. Definitions are provided under Ind. Code § 34-4-12.6-1. Under subsection (c) thereof, a "peer review committee" means a committee having the responsibility of evaluation of qualification of health care providers or of patient care rendered by health care providers. The criteria for composition of the committee is set out in the statute. These include committees organized by a professional staff of a hospital or a governing board of a hospital. A physician is included in the definition of professional health care provider and is subject to the evaluation of patient care set forth in the Indiana Code. Evaluation of patient care includes:

> "(2) The propriety, appropriateness, or necessity of care rendered by a professional health care provider; and
>
> (3) The reasonableness of the utilization of services, procedures and facilities in the treatment of individual patients. Ind. Code § 34-4-12.6-1(b).

Further definitions state:

> "(e) As used in this chapter 'personnel of a peer review committee' means not only members of the committee but also all of the committee's employees, representatives, agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serves a peer review committee in any capacity.

> (f) As used in this chapter 'in good faith' refers to an act taken without malice after a reasonable effort to obtain the facts of the matter and in the reasonable belief that the action taken is warranted by the facts known. In all actions to which this chapter applies, good faith shall be presumed; and malice shall be required to be proven by the person aggrieved." Ind. Code § 34-4-12.6-1.

A professional health care provider under investigation is provided certain procedural rights and privileges pursuant to statute. These include the right to see any records accumulated by a peer review committee pertaining to his practice and to appear before the committee with representation to hear all charges and findings and to offer rebuttal information. The statute provides for one evidentiary hearing before the peer review committee of the medical staff and one appellate hearing before the governing board of the hospital. Ind. Code § 34-4-12.6-2.

The legislature provided protection for the participants in the peer review procedure proceedings.

> "Immunity—(a) There shall be no liability on the part of, and no action of any nature shall arise against, the personnel of a peer review committee for any act, statement made in the confines of the committee or proceeding thereof made in good faith in regard to evaluation of patient care as that term is defined and limited in section 1(b) of this chapter." Ind. Code § 34-4-12.6-3.

As indicated earlier, good faith, by statute, is presumed, and malice is required to be proven. Ind. Code § 34-4-12.6-1(f).

REASONS FOR DENYING THE WRIT

1. INDIANA'S LEGISLATIVE PROGRAM REQUIRING PEER REVIEW IS A CLEARLY ARTICULATED AND AFFIRMATIVELY EXPRESSED STATE POLICY MEETING ALL REQUIREMENTS FOR THE PARKER EXEMPTION FROM FEDERAL ANTITRUST LAWS.

A. PARKER DOCTRINE

This Court in *Parker v. Brown,* 317 U.S. 341, 87 L.Ed. 315, 63 S.Ct. 307 (1943), first articulated the state action doctrine under the Sherman Antitrust Act. It is based on the dual sovereignty of the federal and state governments. This Court indicated that, pursuant to the supremacy clause, there are areas where Congress can nullify state actions. However, the court also articulated the rule that an unexpressed intention by Congress to overrule a state statute would not be lightly inferred.

In *Parker,* California adopted a "marketing program" for the 1940 raisin crop which restricted competition among growers and maintained price levels in the distribution of raisins from the growers to the packers. The California legislature's declared purpose was to conserve the agricultural wealth of California and to prevent economic waste in the marketing of agricultural products. This Court construed the program's authority as being derived from the legislative command of the state and assumed that the program would violate the Sherman Act if done without state involvement. It further assumed that Congress had constitutional authority to prohibit this state program. The state's purpose was presumed to restrict competition among growers and to maintain prices of agricultural commodities. A state commission was appointed by the governor. A committee selected from among the growers was to formulate and administer the program subject to the approval of the Director of Agriculture. The court set forth the policy considerations for this doctrine as follows:

"We find nothing in the language of the Sherman Act or in its history which suggests that its purpose was to restrain a state or its officers or agents from activities by its legislature. In a dual system of government in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its officers and agents is not lightly to be attributed to Congress." Id. at 350, 351

B. THE STATE MUST IN FACT HAVE ACTED

In *Goldfarb v. Virginia State Bar,* 421 U.S. 773, 44 L.Ed. 2d 572, 95 S.Ct. 2004 (1975) the court found that a minimum fee schedule published by the Fairfax County Bar Association was price fixing subject to Sherman Act proscription. The court first noted that attorneys are subject to regulation by the Supreme Court of the state, here Virginia. It further noted that the state bar was, for some purposes, a state agency, although the Fairfax County Bar Association was, in all respects, a private party. The court further noted that the Virginia Supreme Court had adopted ethical codes dealing with fees which explicitly directed attorneys not to be controlled by fee schedules. The fee schedule was initially promulgated by the state bar which apparently had authority in Virginia to act as an administrative agency of the court in investigating and reporting violation of rules and regulations adopted by the court.

The Supreme Court indicated:

"The threshold inquiry in determining if an anticompetitive activity is state action of the type the Sherman Act was not meant to proscribe is whether the activity is required by the state acting as sovereign. (citations omitted). Here we need not inquire further into the state action question because it cannot fairly be said that the state of Virginia through its Supreme Court rules required the anticompetitive activities of either respondent. Respondents have pointed to no Virginia statute requiring their activities; state law simply does not refer to fees,

leaving regulation of the profession to the Virginia Supreme Court . . . ." Id at 790

The court observed that the state bar did not have the authority to act as sovereign and that the state Supreme Court had not so acted. It is clear that if the sovereign had acted, that action would not be barred by the Sherman Act. Further the court was careful to note the state interest in the regulation of professions and stated as follows:

> "We recognize that the states have a compelling interest in the practice of professions within their boundaries, and that as part of their power to protect the public health, safety and other valid interests they have broad power to establish standards for licensing practitioners and regulating the practice of professions. We also recognize that in some instances the State may decide that 'forms of competition usual in the business world may be demoralizing to the ethical standards of a profession' . . .
>
> In holding that certain anticompetitive conduct by lawyers is within the reach of the Sherman Act, we intend no diminution of the authority of the State to regulate its professions." Id. at 792, 793

Unlike *Goldfarb,* we have a situation wherein the state legislature, as sovereign, has required that peer review committees be formed and that they review and evaluate the privileges of physicians on hospital staffs. Under Indiana law, a hospital and its medical staff must establish and implement peer review.

C. COMPULSION IS NOT REQUIRED

The Petitioner originally relied on the case of *United States v. Southern Motor Carriers Rate Conference,* 702 Fed. 2d 535 (5th Cir. 1983). As this court is aware, the Fifth Circuit had held that private parties would be immune from federal antitrust liability only if the state compelled the specific anticompetitive conduct at issue. This court reversed the Fifth Circuit in *Southern Motor Carriers Rate Conference, Inc., et al.*

v. United States, ____ U.S. ____, 82-1922 (March 27, 1985), 53 L.W. 4422. Prior to this court's decision, Petitioner contended that there was a conflict or ambiguity among the circuits regarding this issue. Obviously, it has now been resolved. This court ruled that:

> "The *Midcal* test does not expressly provide that the actions of a private party must be compelled by a state in order to be protected from the federal antitrust laws." Id. at 4424
>
> "Moreover, a state policy that expressly *pemits,* but does not compel, anticompetitive conduct may be 'clearly articulated' within the meaning of *Midcal.* Our holding today does not suggest, however, that compulsion is irrelevant. To the contrary, compulsion often is the best evidence that the state has a clearly articulated and affirmatively expressed policy to displace competition." Id. at 4425
>
> "Parker immunity is available only when the challenged activity is undertaken pursuant to a clearly articulated policy of the state itself, such as the policy approved by a state legislature . . . . " Id. at 4426

D. INDIANA'S STATUTES COVER PEER REVIEW

Under the standards set forth by this court, we now look to the legislative and regulatory program adopted by the State of Indiana to ascertain whether the Seventh Circuit erred in its determination that "the State of Indiana has 'clearly articulated and affirmatively expressed the state policy' that hospital medical staffs are to form peer review committees and that such committees are to review the quality and necessity of the care provided patients, to evaluate the qualifications of staff members, and review the merits of any recommendation against a staff member." *Marrese v. Interqual,* 748 Fed. 2d 373 (7th Cir. 1984).

The Petitioner contends that the Seventh Circuit opinion is based on a generalized theory that pervasive regulation of a profession is evidence of the legislature's intent to displace

competition. The question is much narrower—is Indiana's regulation of peer review state action under the *Parker* doctrine? It is true that Indiana has extensive regulation of the medical profession and of hospitals. However, Respondents do not contend that any action by a professional is automatically exempt from federal antitrust laws because of that state regulation. No fair reading of the opinion in this case could leave the impression that the Seventh Circuit based its decision on generalized regulation. The contentions involved in this case are quite specific. Dr. Marrese has challenged the Respondents' conduct and motives as participants in the medical peer review proceeding at Deaconess Hospital involving Dr. Marrese.

There can be little question that Indiana has, through its legislature, established policies regarding peer review requirements of hospitals. Included in the statutory requirements placed upon hospitals are that the governing board of the hospital *shall* be responsible for the appointment of members of the medical staff and the assignment of privileges to the members of the medical staff with the advice and recommendations of the medical staff. The medical staff *shall* have the responsibility of reviewing the professional practices in the hospital, and the review *shall* include the quality and necessity of care provided patients. Ind. Code § 16-10-1-6.5.

Pursuant to regulations adopted by the Indiana State Board of Health, a state agency, the governing body of the hospital is *required* to adopt by-laws by which the hospital will function, to approve rules and regulations of the medical staff (including audit procedures to assure quality of care) and to appoint the members of the medical staff and assign privileges. The regulations also *require* that the medical staff review the professional practices in the hospital. The medical staff, with the approval of a hospital governing board, is required to adopt by-laws, rules and regulations, including provisions for appointment to staff membership and delineation of privileges. All of these documents are to be reviewed by the State Board of

Health. 410 IAC 15-1-1 et seq. The State Board is required to periodically inspect hospitals to be sure that they continue to comply with state requirements. Ind. Code § 16-10-1-13. Hospital licenses are issued for a period of one year and are subject to suspension or revocation if the hospital violates any of the provisions of the legislative scheme and the rules and regulations adopted pursuant thereto. Ind. Code § 16-10-1-9 and § 16-10-1-10; 410 IAC 15-1-2.

The Indiana legislature has specifically provided for peer review and required that hospitals and their medical staff must undertake medical peer review which includes the quality and necessity of care provided to patients. Ind. Code § 16-10-1-6.5. In this same section, the legislature also provides:

> "The members of any medical staff committee organized for the purpose of conducting medical review, being retrospective and not a part of current patient care, shall have an absolute immunity from civil liability for communications made in committee meetings, and reports and recommendations made by the committee arising from deliberations by the committee to the governing board of the hospital or another dul authorized medical staff committee." Ind. Code § 16-10-1-6.5 (d)

E. INDIANA'S STATUTES PROVIDE FOR IMMUNITY

The legislature also enacted a separate chapter providing immunity for peer review committees. Ind. Code § 34-4-12.6-1 et. seq. A peer review committee is statutorily defined and includes all of the defendants herein. Ind. Code § 34-4-12.6-1. The legislature then provides immunity as follows:

> "*Immunity*-(a) There shall be no liability on the part of, and no action of any nature shall arise against, the personnel of a peer review committee for any act, statement made in the confines of the committee, or proceeding thereof made in good faith in regard to evaluation of patient care as that term is defined and limited in Section 1(b) of this chapter." Ind. Code § 34-4-12.6-3(a)

It defines good faith as follows:

> "(f) As used in this chapter, 'in good faith' refers to an act taken without malice after a reasonable effort to obtain the facts of the matter and in the reasonable belief that the action taken is warranted by the facts known. In all actions to which this chapter applies, good faith shall be presumed; and malice shall be required to be proven by the person aggrieved." Ind. Code § 34-4-12.6-2(f)

The legislature provided that a physician whose privileges were under question would be "entitled to only one (1) evidentiary hearing before a peer review committee of the medical staff and one (1) additional hearing on appeal before the governing board of the hospital." Ind. Code 34-4-12.6-2(b)

The state legislature then further goes on to require

> "(b) The governing board shall report, in writing, to the Indiana Medical Licensing Board the results and circumstances of any final, substantive, and adverse disciplinary action taken by the governing board regarding a position on the medical staff, or an applicant for the medical staff, if the action results in voluntary of involuntary resignation, termination, non appointment, revocation, or significant reduction of clinical privileges of staff membership. . . . The governing board and its employees, agents, consultants, and attorneys have absolute immunity from civil liability for communications, discussions, actions taken and reports made concerning disciplinary action or investigation taken or contemplated, if such reports or actions are made in good faith and without malice." Ind. Code § 16-10-1-6.5(b)

F. SPECIFIC ENUMERATION OF ANTI-COMPETITIVE EFFECTS IS NOT REQUIRED

It is impossible not to conclude that the legislature of the State of Indiana contemplates and requires medical peer review. Given the immunities and reporting requirements set forth in the statute, it is also indisputable that the Indiana legislature anticipated that some physicians would be in-

voluntarily removed from hospital staffs. The Petitioner contends that this does not constitute a "very specifically expressed state policy". Except for requiring that the legislature expressly state in the statute or legislative history that it intends that the required conduct have anticompetitive effect, it is hard to imagine how the legislature could have made its intent more specific, and it is quite difficult to believe that the Indiana legislature did not choose to use medical peer review for medical quality control over unregulated competition. This court has never accepted a requirement that the legislature specifically enumerate all anticipated effects expected and, indeed, has specifically rejected that as recently as two months ago. *Town of Hallie v. City of Eau Claire,* ____ U.S. ____, 82-1832 (1985), 53 L.W. 4418. This court specifically found that a requirement that the legislature catalog anticompetitive effects was unrealistic and might have deleterious consequences. The clear articulation requirement of the state action test is satisfied if the statutory provisions show that the legislature contemplated the kind of action complained of. Indiana has clearly done so here.

II.

THERE IS NO CONFLICT AMONG THE CIRCUITS REGARDING THE TEST USED BY THE SEVENTH CIRCUIT.

The Petitioners originally argued that there was a conflict among the circuits regarding whether compulsion was required before the court could find that there was a clearly and affirmatively expressed state policy. Since this court has recently ruled on that issue, that alleged conflict no longer remains.

Petitioners, originally cited two cases for another standard. They are *Capital Telephone Company v. New York Telephone Company,* 84-7176 (2nd Cir. 12/18/84) and *Hybud Equipment Corp. v. City of Akron,* 742 F. 2d 949 (6th Cir. 1984), cert. denied, (April 1, 1985). Both cases found that there was state action in the circumstances before them. The court in *Capital*

Telephone indicated that it was following the test set by this court in *California Retail Liquor Dealers Assn v. Midcal Aluminum, Inc.*, 445 U.S. 97, 63 L.Ed 233, 100 S.Ct. 937 (1980). The *Capital Telephone* court rejected the specificity requested by the plaintiff here and stated that activities that are reasonably necessary or related to the subject of the legislation should be included within the scope of the immunity. In *Hybud Equipment Corp. v. City of Akron*, 742 F. 2d 9494 (6th Cir. 1984), the court also upheld a determination of a clearly and affirmatively expressed state policy despite their inability to find a direct statutory provision for it. The court stated:

> "If the challenged anticompetitive restraint of a non-sovereign state representative, for which there is no express statutory provision, is necessary to carry out the representatives' mandate, then a legislative intent to displace competition may be inferred from the legislature's delegation of authority." Id at 960

Both of these cases adopted a broader standard than that used by the Seventh Circuit here. The Seventh Circuit in this case noted that there is a legislative requirement that hospitals and their medical staffs form peer review committees. Here there is specific statutory authority requiring the hospital and its medical staff to engage in peer review. There simply is no conflict demonstrated by these cases.

The *Amicus* brief cites the case of *Ratino v. Medical Service of the District of Columbia*, 718 F. 2d, 1260 (4th Cir. 1983) as being in conflict with the decision of the Seventh Circuit. Respondents believe that the intervenors have misread both cases. *Ratino* alleged a price fixing conspiracy. Blue Shield had an insurance plan which provided for payment of usual, customary and reasonable fees. When Blue Shield believed a fee was not reasonable, it referred that dispute to a fee review committee which was made up of physicians. One defense raised was that the conduct was exempt under the *Parker* doctrine. The Fourth Circuit examined the law of the

State of Maryland which provided for a commission on medical discipline. The commission was authorized to take certain disciplinary actions for enumerated causes including gross and wilful and continued overcharging for professional services. Apparently the commission could request committees of local medical societies to conduct investigations. However, under the facts of that case, the committee reviewing usual, customary and reasonable charges for Blue Shield was not one appointed by the commission on medical discipline. Further the court noted that the Maryland Statute did not provide for any medical committees to review or police physician charges. That case is substantially different from the case at issue herein. In fact all of these cases are consistent in the standards applied and differ because the nature and extent of the state's programs are factually dissimilar.

First, the Indiana legislature clearly has provided for quality review by hospital peer review committees. The Petitioners and Intervenors suggest, in effect, that a state legislature cannot choose to favor medical staff peer review for quality control purposes over the Sherman Antitrust Act. That is directly contrary to the theory of *Parker* and has been decided adversely to their position by this court many times.

The real task of the courts continues to be that they must review the state policy to see what it provides. The Fourth Circuit found that Maryland had not authorized physician committees to engage in price fixing. The state policy, here enacted by the legislature, must be reviewed to see if it meets standards established by this court. The states are and should be free from federal antitrust law if they adopt policies meeting the standards of this court which entitle them to that exemption. The Seventh Circuit reviewed Indiana's program, enacted directly by its legislature, and found that Indiana's statutes provided medical staff peer review for quality control.

3. THE STATE OF INDIANA ACTIVELY SUPERVISES THE MEDICAL PEER REVIEW PROCESS.

California Liquor Dealers v. Midcal Aluminum, 445 U.S. 97, 63 L.Ed. 2d 233, 100 S.Ct. 937 (1980) has given us the

basic test for the state action exemption relative to private parties. That case involved a private setting of prices for wine pursuant to California Statute. This court articulated the two requirements for antitrust immunity:

> "First, the challenged restraint must be 'one clearly articulated and affirmatively expressed as state policy'; Second, the policy must be 'actively supervised' by the state itself." Id. at 105

This court found that California's wine pricing programs satisfied the first standard, but because there were no standards for price fixing or review of the results thereafter, the court found that there was insufficient state involvement to allow the state action exemption for this price fixing arrangement. The courts of California had also refused to enforce it.

The State of Indiana has set forth a statutory, regulatory and judicial program of supervision and regulation. It has a strong and valid interest in protecting the health and welfare of its citizens, and its statutes and regulations demonstrate the extensive program adopted by the state to protect those interests.

Both physicians and hospitals must be licensed by Indiana before they can treat the public. Ind. Code § 25-22.5-2-1 et seq. and Ind. Code § 16-10-1-1 et seq. Pursuant to regulations adopted by the Indiana State Board of Health, the governing body of the hospital is required to approve rules and regulations of the medical staff (including audit procedures to assure quality of care) and to appoint the members of the medical staff and assign privileges. These must be made available and are subject to review by the State Board of Health. 410 IAC 15-1-1 et seq. As indicated previously, the State Board of Health is required to conduct inspections to be sure that the hospital is, in fact, complying with state regulations, including those involving peer review, in order to maintain its license.

Indirect administrative review is provided by the requirement that the hospital governing board report any adverse proceedings regarding medical staff privileges to the medical licensing board. Ind. Code § 16-10-1-6.5. The legislature of the State of Indiana has required hospitals to engage in peer review and has contemplated the removal of some physicians from hospital staffs. It has also provided for immunities subject to limited judicial review as set forth in Ind. Code § 34-4-12.6-1 et seq.

Hospitals are subject to sanctions for failure to comply with Indiana statutes and regulations. The hospital is required to have a fair hearing plan and peer review committees. The State of Indiana has provided review of the actual planning process by the Hospital Council and State Board of Health. They have an obligation to periodically inspect the hosptial and have the right to review specific proceedings which are required to be made available to them.

The State of Indiana has chosen to provide additional review, subject to statutory standards, through the courts of Indiana. Under Indiana procedure, Dr. Marrese was entitled to judicial review under the standards established. In fact, he challenged the peer review process in the state court which found that Dr. Marrese had not sustained his burden of proof in proving malice. The court further found that the proceedings were taken pursuant to the peer review provisions at issue herein. As indicated previously, Indiana provides immunity for participants in peer review proceedings for actions taken therein unless their actions are found not to be in good faith. Dr. Marrese has exhausted his appeals from the Indiana state action, though this occurred subsequent to the District Court's dismissal of the claimed antitrust cause of action.

Dr. Marrese's position is that the Medical Licensing Board, which receives the hospital's report of adverse actions taken against him, does not directly regulate the hospital's procedure and thus the state has no method of supervision. As indicated,

that is only a portion of the review provided by the State of Indiana in its regulation of peer review.

In Indiana, the legislature has chosen a level of review to insure due process and fair dealing for all physicians involved in the peer review process. It has also, however, determined that its policy of requiring peer review will be best served by the limited review found in the Indiana Code. The legislature has designated both administrative agencies and the courts as appropriate entities for reviewing the conduct of peer review committees under standards set by it. However, it is important to note that the Indiana legislature has made the policy decision to set both the standards and the forum for that review. Indiana has provided for limited judicial review for peer review committees and immunities for the participants in those committees. That clearly manifests the legislature's intent to have direct, but limited, review by the Indiana courts of any peer review proceeding. The program insures due process and avoids vidictive private proceedings. However, it also clearly manifests a state legislative policy preferring peer review to maintain medical quality. Indiana's legislature has recognized that the more generalized review called for by Dr. Maresse could result (and we believe would result) in substantial reluctance on the part of physicians and hospitals to engage in peer review. The legislature chose to provide immunity to participants in peer review, and chose limited judicial review.

The Seventh Circuit explained the Legislature's concern that the threat of extensive litigation, with its attendant financial burdens and potential liabilities, is onerous and would logically discourage peer review. The Indiana courts have followed Indiana's standards for review. *Yarnell v. Sisters of St. Francis Health Services,* 446 N.E. 2d 359 (Ind. App. 1983). Many courts have been conscious of the appropriateness of encouraging peer review. Indeed Congress has also required

medical peer review for quality control for those receiving federal funds through Medicare. A health care practitioner can be disqualified by an adverse decision of a private peer review contractor whose recommendation is automatically effective after 120 days unless the Secretary reverses it or, in some cases, a court does so. Congress also granted immunity for these peer review proceedings. *Peer Review Improvement Act of 1982,* P.L. 97-248, § 141-150.

Courts have recognized that imposing potential antitrust antitrust liability would significantly dampen the willingness of physicians to be involved in peer review. *Pontius v. Childrens Hospital,* 552 Fed. Supp. 1352 (W. D. Penn. 1982). This court, in a somewhat different context, has noted that a hospital has an unquestioned right to exercise control over the identity and number of doctors to whom it accords staff privileges pursuant to state law and regulation. *Jefferson Parish Hospital District No. 2 v. Hyde,* ____ U.S. ____, 80 L.Ed. 2d 2, 104 S.Ct., 1551 (1984). All of this is consistent with the decision of the Indiana Legislature to provide immunity and limited judicial review.

The case of *Bates v. State Bar of Arizona,* 443 U.S. 350, 53 L.Ed. 2d 810, 97 S. Ct., 2691 (1977) reinforces this court's review of the factors considered in applying the state action immunity to the professions. *Bates* involved advertising restraints by attorneys. Enforcement procedures were handled by a committee of the State Bar of Arizona. The plaintiffs therein argued that the state court immunity doctrine should not apply both because a private party was involved and because the limits prescribed by Arizona were "not tailored so as to intrude upon the federal interest to the minimum extent necessary." Id. at 361. This court rejected plaintiff's position on antitrust grounds and noted the state's substantial interest in the regulation of the activities of the bar. The case was eventually reversed on First Amendment grounds, but the state action immunity doctrine was found to be applicable.

Indiana has chosen to monitor the plans and process of peer review through administrative agencies, primarily, though not exclusively, through the Hospital Licensing Council and the

State Board of Health. It has further chosen to make available a judicial remedy for physicians whose staff privileges had been revoked when that revocation has been done with malice. This can be analogized to the admittedly adequate supervision discussed in *Southern Motor Carriers Rate Conference, Inc. v. United States,* ___ U.S. ____, 82-1922 (1985), 53 L.W. 4422. In that situation, private parties submitted proposed rates to the state agencies which became effective if the state agency took no action within a specified period of time. In this case, hospitals submit their plans for peer review to the state agencies as a requirement for maintaining their licenses. The state agency has the duty to review the policy set forth in the fair hearing plan. It also has the right to review the proceedings of any peer review panel. The Petitioner has the right to judicial review under standards set by the Indiana legislature as a protection against the misuse of peer review proceedings.

The Petitioners and Intervenors have taken the position that there should be discovery and an evidentiary hearing to determine whether state action applies. That contradicts the rationale behind the state action doctrine. As this court said in *Hoover v. Ronwin,* ____ U.S. ____, 80 L.Ed. 2d 590, 104 S.Ct. 1989 (1984):

> "The reasoning adopted by the dissent would allow Sherman Act plaintiffs to look behind the actions of state sovereigns and base their claims and perceived conspiracies to restrain trade among the committees, commissions or others who necessarily must advise the sovereign. Such a holding would emascuate the *Parker v. Brown* doctrine." Id. at 607.

Hoover involved involved the actions of a committee of the state bar examiners of the State of Arizona. The plaintiff therein alleged the same type of boycott as has Dr. Marrese, and the parallels regarding alleged motivation are similar. This court found the determinative issue to be whether there was state action as was originally articulated in *Parker v. Brown,* 317 U.S. 341, 87 L.Ed. 315, 63 S.Ct. 307 (1943).

If there is state action, the motivation of the participants is immaterial. It is immaterial because the State, here Indiana, has chosen to regulate and supervise this field which precludes antitrust review.

A fair reading of Dr. Marrese's complaint demonstrates that the basis for his lawsuit is his belief that peer review proceedings were instituted against him which resulted in his removal from the staff at Deaconess Hospital. His complaint alleges that Respondents acted in various ways that were improper, and that he should be entitled to an antitrust review of these proceedings. Indiana has chosen a different statutory program which puts a greater emphasis on the need to have quality review of health care professionals in order to protect the public. That is not the program that Dr. Marrese wants, but it is the program adopted by the legislature of the State of Indiana. There is nothing in the Sherman Antitrust Act indicating that the state could not and should not adopt such a program, and the courts continue to recognize the states' interest in regulating the professions in ways that they see fit. That is what Indiana has done.

Both the Petitioners and the Intervenors argue that there is a federal supremacy issue here. There is no question that, within its constitutional authority, Congress could choose to pass legislation which will void otherwise applicable state legislation. However, the supremacy argument asserted has been decided adversely to the Petitioners in *Parker v. Brown,* 317 U.S. 341, 87 L.Ed. 315, 63 S.Ct. 307 (1943). The question decided in *Parker* was whether the Congress intended to prohibit state governments from pursuing policies which may be inconsistent with the Sherman Antitrust Act. The *Parker* court found that Congress clearly did not have such an intent and that it would not be lightly inferred. In effect, the Petitioner and the Intervenors argue what has been termed by commentators as the exemption doctrine. Exemption requires an analysis of potential conflicts between two statutes of the same sovereign. The courts in that situation try to construe

statutes to avoid such a conflict, and the presumption is against an implied exemption from one of the statutes. Thus, the courts have relatively narrowly construed the many exemptions to the Sherman Antitrust Act enacted by Congress. These range from patents through insurance with many stops in between.

The preemption doctrine is significantly different. Preemption deals with enactments of two sovereigns, one federal and the other state. The inquiry for preemption is whether the federal government has exclusively occupied a particular field or whether federal law in that area is so flatly in conflict with state law that the two cannot coexist. *Handler, "Antitrust-1978",* 78 Columbia Law Review 1374 (1978). In exemption analysis, there is a presumption in favor of the antitrust laws and against any implied repeal. In preemption analysis, the presumption is in favor of state law and against the exercise of federal power. The *Parker* case clearly demonstrates the state action doctrine evolved out of a preemption analysis, and the court found that Congress did not intend to preempt state action. The Petitioner advances the supremacy argument because he recognizes that the Indiana legislature's provision for immunity of peer review committees would bar plaintiff's cause of action. Ind. Code § 34-4-12.6-1 et. seq.

The Intervenors claim that the opinion of the Seventh Circuit would in some way limit the ability of the States to regulate health care services and the licensing of physicians and hospitals. Obviously there is nothing in the state action doctrine which so limits the states. The state action doctrine reflects a decision by Congress and this court that the states are free to regulate activities without the constraint otherwise imposed by the Sherman Antitrust Act. The states, as sovereigns, are not constrained in any way by the state action doctrine. They would be substantially constrained if the Intervenors' position

were adopted because it, effectively, asks that the court not allow the states to choose medical peer review for quality control over antitrust concerns. The cite no authority for that proposition, because, since *Parker,* the issue has been closed.

CONCLUSION

Respondents respectfully submit that the Seventh Circuit's opinion in this case follows this court's two pronged test for determining whether state regulation of private parties is shielded from the antitrust laws. These are that the challenged restraint must be one clearly articulated and affirmatively expressed as state policy and that there must be active state supervision of its implementation. There is no conflict among the circuits on these tests, so that there is no necessity for this court's supervision. Wherefore, for the reasons discussed herein, the Respondents request that the court deny the Petition for Writ of Certiorari.

Respectfully Submitted,

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APPENDIX

INDIANA STATUTES AND REGULATIONS INVOLVED

(For convenience the sections cited by the Petitioners as well as those added by Respondents are contained herein.)

16-10-1-1 Power to license and regulate

Sec. 1. From and after the passage of this chapter the state board of health shall be empowered to license and regulate hospitals and ambulatory outpatient surgical centers. Such licensing and regulations shall be accomplished through a council to be created in the manner hereinafter provided, and such other employees as are hereinafter provided for.

16-10-1-2 Definitions

Sec. 2. The word "board" as used in this act, unless otherwise indicated, shall mean the state board of health. The word "council," unless otherwise indicated, shall mean the council herein provided for.

16-10-1-3 Council; members; appointment, qualifications, term, vacancies, chairman

Sec. 3. The council shall consist of eight (8) members, who shall be appointed by the governor within thirty (30) days after this act becomes effective, one of whom shall be a member of the medical profession having an unlimited license to practice medicine in the state of Indiana, one (1) of whom shall be a registered nurse, four (4) of whom shall be persons engaged in hospital administration. The two (2) remaining members shall be ex officio members, one (1) of whom shall be appointed by the governor from the state department of public welfare, and the other of whom shall be appointed from the state board of health. Of the original hospital administrators appointed one (1) shall serve for one (1) year, one (1) for two (2) years, one (1) for three (3) years and one (1) for four (4) years. The original members appointed from the medical

profession and the nursing profession shall serve for three (3) years. The members appointed from the department of welfare and board of health shall serve for two (2) years. All subsequent appointments shall be for four (4) years, except that in case of a vacancy the appointee shall serve for the remainder of the unexpired term. Any vacancy shall be filled from the same group as was represented by the outgoing member. The governor shall appoint a chairman and a chairman pro tempore.

16-10-1-6.5. Management of hospital—Appointment to medical staff—Medical staff—Medical review—Civil liability.—The governing board of the hospital shall be the supreme authority in the hospital, responsible for the management, operation, functioning and control of the hospital, and the appointment of the members of the medical staff and the assignment of privileges to members of the medical staff with the advice and recommendations of the medical staff consistent with their individual training, experience, and other qualifications. The medical staff of a hospital shall be an organized group which shall be responsible to the governing board for the clinical and scientific work of the hospital, advice regarding professional matters and policies to the governing board, and shall have the responsibility of reviewing the professional practices in the hospital for the purpose of reducing morbidity and mortality, and for the improvement of the care of patients in the hospital. This review shall include, but shall not be limited to, the quality and necessity of the care provided patients and the preventability of complications and deaths occurring in the hospital. The members of any medical staff committee organized for the purpose of conducting medical review, being retrospective and not a part of current patient care, shall have an absolute immunity from civil liability for communications made in committee meetings, and reports and recommendations made by the committee arising from deliberations by the committee to the governing board of the hospital or another duly authorized medical staff committee.

16-10-1-6.5 Governing board; disciplinary actions; reports; medical staff

Sec. 6.5. (a) The governing board of the hospital shall be the supreme authority in the hospital, responsible for the management, operation, functioning, and control of the hospital, and the appointment of the members of the medical staff and the assignment of privileges to members of the medical staff with the advice and recommendations of the medical staff consistent with their individual training, experience, and other qualifications.

(b) The governing board shall report, in writing, to the Indiana medical licensing board the results and circumstances of any final, substantive, and adverse disciplinary action taken by the governing board regarding a physician on the medical staff, or an applicant for the medical staff, if the action results in voluntary or involuntary resignation, termination, nonappointment, revocation, or significant reduction of clinical privileges or staff membership. Such a report shall not be made for nondisciplinary resignations nor for minor disciplinary action taken regarding physicians. The governing board and its employees, agents, consultants, and attorneys have absolute immunity from civil liability for communications, discussions, actions taken, and reports made concerning disciplinary action or investigation taken or contemplated, if such reports or actions are made in good faith and without malice.

(c) The medical staff of a hospital shall be an organized group which shall be responsible to the governing board for the clinical and scientific work of the hospital, advice regarding professional matters and policies to the governing board, and shall have the responsibility of reviewing the professional practices in the hospital for the purpose of reducing morbidity and mortality, and for the improvement of the care of patients in the hospital. This review shall include, but shall not be limited to, the quality and necessity of the care provided

patients and the preventability of complications and deaths occurring in the hospital.

(d) The members of any medical staff committee organized for the purpose of conducting medical review, being retrospective and not a part of current patient care, shall have an absolute immunity from civil liability for communications made in committee meetings, and reports and recommendations made by the committee arising from deliberations by the committee to the governing board of the hospital or another duly authorized medical staff committee.

16-10-1-7 Necessity of license; exemption of federal hospitals

Sec. 7. After January 1, 1946 no person, partnership, association, corporation, or any state, county or local governmental unit or any division, department, board or agency thereof shall establish, conduct, operate or maintain in the State of Indiana any hospital or ambulatory outpatient surgical center, as defined in this chapter, without having a license therefor as hereinafter provided. Hospitals operated by the federal government shall be exempt from the provisions of the chapter.

16-10-1-9 Application for license; requisites; procedures; issuance; renewal; fees

Sec. 9. Any person, partnership, association, corporation, or any state, county, or local governmental unit, or any division, department, board or agency thereof, in order to lawfully establish, conduct, operate, or maintain a hospital or an ambulatory outpatient surgical center in this state, shall obtain a license therefor from the board, upon the approval and recommendation of the council in the following manner:

(a) The applicant shall submit an application on a form to be prepared by the council with the approval of the state board of health, showing that the applicant is of reputable and

responsible character and able to comply with the minimum standards for a hospital or an ambulatory outpatient surgical center and with rules lawfully promulgated under this chapter. The application must contain the following additional information:

(1) the name of the applicant;

(2) the type of institution to be operated;

(3) the location of the institution;

(4) the name of the person to be in charge thereof; and

(5) such other information as the council, with the approval of the board, may require.

(b) The application must be accompanied by a licensing fee computed at the rate of four dollars ($4) per available hospital bed.

(c) The council may recommend and approve the issuance of a license upon the application without further evidence, or, in its discretion, it may have a hearing on the application and conduct its own investigation, to determine whether a license ought to be granted.

(d) If, after hearing, the council finds that a license should not be granted it shall so notify the applicant. The decision of the council shall be final.

(e) If, after hearing, the council finds that the applicant complies and will in the future comply with the provisions of this chapter and the rules promulgated under this chapter, then the council shall recommend and approve the issuance of a license, and thereupon a license shall be issued by the board licensing the applicant to operate the hospital or ambulatory outpatient surgical center for one (1) year.

(f) A license to operate a hospital or ambulatory outpatient surgical center shall expire one (1) year after the date

of issuance. It shall not be assignable or transferable, shall be issued only for the premises named in the application, and shall be posted in a conspicuous place in the facility. It may be renewed from year to year, upon the payment of a renewal fee computed at the rate of four dollars ($4) per available hospital bed.

16-10-1-10 Suspension or revocation of license

Sec. 10. The board may suspend or revoke a license issued hereunder on the recommendation of the council on any of the following grounds:

(a) Violation of any of the provisions of this chapter or of the rules and regulations issued pursuant hereto;

(b) Permitting, aiding, or abetting the commission of any illegal act in such institution; or

(c) Conduct or practice found by the council to be detrimental to the welfare of the patients of such institution.

The procedure governing the suspension or revocation of any license shall be as follows:

(1) A complaint shall be filed by the board stating facts constituting a ground or grounds for revocation or suspension.

(2) The licensee shall be given notice of not less than thirty (30) days of the time and place for a hearing before the council on said complaint, which notice shall be sent by registered mail to the licensee at the address shown in his application. The licensee shall be entitled to be represented by legal counsel at said hearing.

(3) The council may recommend to the board after such hearing either that the license be suspended or that it be revoked.

(4) If the council recommends suspension of a license it may also recommend the conditions to be met by the licensee

during the period of suspension in order to entitle the licensee to resume operation of the said hospital or ambulatory outpatient surgical center on the existing license.

(5) If the council recommends either suspension or revocation the board shall, pursuant thereto, enter an order in accordance therewith in which order shall be set forth the grounds of such suspension or revocation.

(6) The council may, in its discretion, after hearing, hold the case under advisement and make a recommendation to the board as to requirements to be met by said licensee in order to avoid either suspension or revocation; and in such cases the board shall enter an order accordingly and notify the licensee thereof by registered mail. Then if the licensee complies with such order and proves that fact to the satisfaction of the council, the council shall recommend to the board that an order be entered showing satisfactory compliance and dismissing the case because of such compliance, and the board shall enter such an order.

16-10-1-11 Appeals

Sec. 11. Any licensee, or applicant for a license, aggrieved by the action of the council and the board may appeal from such action to the circuit or superior court of the county in which the hospital or ambulatory outpatient surgical center in question is located, or is proposed to be located, by filing a notice and bond in the amount of two hundred dollars ($200) for the payment of costs, in the office of the county clerk of such county, who shall thereupon notify the board that such appeal has been taken. The board shall thereupon cause to be certified to such court a copy of the complaint and of the recommendation of the council and the order of the board in cases of suspension or revocation; or of the application and order of refusal of a license, in any case where a license was refused. The case shall then be docketed as a civil action, with the

applicant or licensee as the plaintiff and the board as the defendant. No further pleading shall be necessary. Such court shall have jurisdiction to the extent that courts exercise jurisdiction over administrative bodies and may enter an order either sustaining the action of the board and council or setting it aside. The clerk of such court shall certify to the board a copy of the decision of such court. An appeal may be had from the decision of such court.

16-10-1-12 Rules and regulations for operation and management of hospital; minimum standards for equipment and patient care

Sec. 12. The council shall have the duty and power to adopt such rules and regulations pertaining to the operation and management of hospitals and ambulatory outpatient surgical centers, and to rescind, amend, or modify such rules and regulations from time to time, as are necessary in the public interest and particularly for the establishment and maintenance of standards of hospitalization required for the efficient care of patients. It shall prescribe, by rules and regulations adopted by it, the minimum standards as to equipment and provision for the care of patients to which an institution must conform in order to operate lawfully as a hospital or as an ambulatory outpatient surgical center.

16-10-1-13 Inspection; exemption from laws relating to hotels, restaurants, etc.

Sec. 13. Every hospital or ambulatory outpatient surgical center, as defined in this chapter, for which a license has been issued, shall be inspected periodically by a duly appointed representative of the board under the rules and regulations to be promulgated under this chapter. Inspection reports shall be prepared on forms prescribed by said council. No institutions or agencies licensed pursuant to the provisions of this chapter shall be required to be inspected or licensed under the laws of

this state relative to hotels, restaurants, lodging-houses, boarding-houses and places of refreshment.

16-10-1-14 Rules and regulations; approval

Sec. 14. All rules and regulations to become effective shall be jointly approved by the council and the board, and promulgated in the manner provided by law for the promulgation of rules and regulations of administrative bodies.

16-10-1-17 Administrative and clerical employees; inspections

Sec. 17. The board is authorized to employ all necessary administrative and clerical employees; and to employ one (1) or more inspectors for such time as in the judgment of the board and council may be necessary, who shall be well experienced in the operation of hospitals, and whose duty it shall be, (a) to visit all institutions coming under the scope of this act, and inspect them in so far as it may be necessary to arrive at the necessary facts required to make a true and informative report to the said council; and, (b) to give advice, aid, and encouragement to such institutions, in maintaining high professional ideals and good care of patients.

25-22.5-2.1. Creation and membership—The medical licensing board of Indiana is created. It shall consist of seven [7] members, not more than four [4] of whom shall be members of the same political party. The members shall be appointed by the governor, and all vacancies occurring on the board shall be filled by the governor. The membership of the board shall consist of:

(1) Five [5] reputable physicians who are graduates of a medical school who hold the degree of doctor of medicine or its equivalent and who hold valid unlimited licenses to practice medicine in Indiana, and who shall serve for terms of four [4] years each;

(2) One [1] reputable osteopathic physician who is a graduate of an accredited osteopathic medical school who holds

the degree of doctor of osteopathy or its equivalent and who holds a valid unlimited license to practice osteopathic medicine in Indiana, who shall serve for a term of four [4] years; and

(3) One [1] member to represent the general public who is a resident of this state and in no way associated with the medical profession other than as a consumer.

25-22.5-2-7. Powers and duties.—The board shall:

(a) Promulgate rules, regulations and forms necessary to implement this article. It may adopt rules and regulations concerning, but not limited to, the following areas:

(i) Qualification by education, residence, citizenship, training and character for admission to an examination for licensure or by endorsement for licensure;

(ii) the examination for licensure itself;

(iii) the license or permit itself;

(iv) Fees for examination, permit, licensure, and registration; and

(v) Reinstatement of licenses and permits;

(b) Administer oaths in matters relating to the discharge of their official duties;

(c) Enforce this article, and assign service bureau personnel duties, as may be necessary in the discharge of the board's duty;

(d) Maintain, through the service bureau, full and complete records of all applicants for licensure or permit and of all licenses and permits issued;

(e) Make available, upon request, the complete schedule of minimum requirements for licensure or permit;

(f) Have the power to issue a temporary permit to an applicant for the interim from the date of application until the next regular meeting of the board;

(g) Have the duty to issue an unlimited license, a limited license or a permit, depending upon the qualifications of the applicant, to any applicant who successfully fulfills all of the requirements of this article; and

(h) Adopt rules establishing standards for the competent practice of medicine or osteopathic medicine, or any other form of practice regulated by a limited license or permit issued under this article.

25-22.5-3-1. Minimum requirements.—The minimum requirements for all applicants for an unlimited license to practice medicine or osteopathic medicine in Indiana must include but are not limited to the following:

(a) [Repealed.]

(b) The applicant must not have a conviction for an act which would constitute a ground for disciplinary sanction under IC 25-22.5-6-2.1(b).

(c) The applicant shall possess the degree of doctor of medicine or doctor of osteopathy or its equivalent from a medical school which was approved by the board as of the time the degree was conferred.

(d) The applicant shall have successfully passed the examination for licensure or shall have satisfied the requirements for licensure by endorsement as prescribed by the board.

(e) The applicant shall be physically and mentally capable of safely engaging in the practice of medicine or osteopathic medicine and shall submit to an examination if deemed necessary by the board to determine such capability.

(f) [Repealed.]

(g) the applicant shall not have had his license previously revoked or suspended by the board or by the licensing agency of any other state by reasons of his inability to safely practice medicine or osteopathic medicine, and those reasons are still valid in the opinion of the board.

(h) The applicant shall have submitted a complete transcript of his educational records, grades and diploma from his medical school with an English translation thereof.

(i) The applicant shall, at the board's discretion, make a personal appearance before it.

25-22.5-6-2.1. Disciplinary sanctions.—(a) As used in this section and section 3[25-22.5-6-3] of this chapter, "practitioner" means an individual who holds an unlimited license, limited license, or permit issued under this article.

(b) A practitioner shall conduct his practice in accordance with the standards established by the board under IC 25-22.5-2-7(h) and is subject to the exercise of the disciplinary sanctions under subsection(e) if, after a hearing, the board finds:

(1) The practitioner has employed or knowingly cooperated in fraud or material deception in order to obtain a license to practice, or has engaged in fraud or material deception in the course of professional services or activities, or has advertised services in a false or misleading manner;

(2) The practitioner has been convicted of a crime which has a direct bearing on the practitioner's ability to continue to practice competently;

(3) A practitioner has knowingly violated any rule adopted by the board under IC 25-22.5-2-7(h);

(4) A practitioner has continued to practice although he has become unfit to practice due to:

(A) Professional incompetence;

(B) Failure to keep abreast of current professional theory or practice;

(C) Physical or mental disability; or

(D) Addiction or severe dependency upon alcohol or other drugs which endangers the public by impairing a practitioner's ability to practice safely;

(5) A practitioner has engaged in a course of lewd or immoral conduct in connection with the delivery of services to patients;

(6) A practitioner has allowed his name or license issued to him under this chapter to be used in connection with any individual who renders services beyond the scope of his training, experience, or competence.[;]

(7) A practitioner, except as otherwise provided by law, has knowingly prescribed, sold, or administered any drug classified as a narcotic, addicting, or dangerous drug to a habitue or addict; or

(8) A practitioner has had a license to practice in another state revoked or suspended by that state on grounds similar to those under this section: A certified copy of the record of suspension or revocation is conclusive evidence of the other state's suspension or revocation.

(c) The board may order a practitioner to submit to a reasonable physical or mental examination if his physical or mental capacity to practice safely is at issue in a disciplinary proceeding.

(d) Failure to comply with a board order to submit to a physical or mental examination shall render a practitioner liable to the summary revocation procedures under subsection (f) [of this section].

(e) The board may impose any of the following sanctions, singly or in combination, when it finds that a practitioner is guilty of any offense under subsection (b) [of this section]:

(1) Permanently revoke a practitioner's license;

(2) Suspend a practitioner's license;

(3) Censure a practitioner;

(4) Issue a letter or reprimand; or

(5) Place a practitioner on probation status and require the practitioner to:

(A) Report regularly to the board upon the matters which are the basis of probation;

(B) Limit practice to those areas prescribed by the board; or

(C) Continue or renew professional education under a preceptor approved by the board until satisfactory degree of skill has been attained in those areas which are the basis of the probation.

The board may withdraw the probation if it finds that the deficiency which required disciplinary action has been remedied.

(f) The board may summarily suspend a practitioner's license for a period of ninety [90] days in advance of a final adjudication or during the appeals process if the board finds that a practitioner represents a clear and immediate danger to the public health and safety if he is allowed to continue to practice. The summary suspension may be renewed upon a hearing before the board, and each renewal may be for a period of ninety [90] days or less.

(g) The board may reinstate a license which has been suspended under this chapter if, after a hearing, the board is satisfied that the applicant is able to practice with reasonable skill and safety to patients. As a condition of reinstatement, the board may impose disciplinary or corrective measures authorized under this chapter.

(h) The board shall seek to achieve consistency in the application of the sanctions authorized in this section, and significant departures from prior decisions involving similar conduct shall be explained in the board's findings or orders.

25-22.5-6-3 Disciplinary proceedings

Sec. 3. Disciplinary Proceedings. (a) Proceedings for the probation of a licensee or a permit holder or the revocation or

suspension of any license or permit to practice medicine or osteopathic medicine in Indiana must be commenced by the filing of written verified charges with the secretary of the board. These charges may be filed by any resident of Indiana, or by the secretary or any member of the board upon information from whatever source in his possession, which causes the member to have reasonable cause to believe that the matter should be filed and placed before the board for its determination. Proceedings for probation of a licensee or permit holder or revocation or suspension of any license or permit to practice medicine or osteopathic medicine in Indiana must be conducted according to the administrative adjudication act of Indiana, IC 4-22-1. Approval by a majority of all members of the board shall be required for any action to be taken.

(b) Any person who files charges or testifies before the board in any disciplinary proceeding is immune from civil liability for damages for any sworn or written testimony made with probable cause and without malice.

(c) The administrator, his staff, counsel, investigators, hearing officers, and the board members are immune from civil liability for damages for conduct within the scope and arising out of the performance of their duties.

34-4-12.6-1. Definitions.—(a) As used in this chapter, "professional health care provider" means:

(1) A physician licensed under IC 25-22.5;

(2) A dentist licensed under IC 25-14;

(3) A hospital licensed under IC 16-10-1;

(4) A podiatrist licensed under IC 25-29;

(5) A chiropractor licensed under IC 25-10;

(6) An optometrist licensed under IC 25-24;

(7) A psychologist licensed under IC 25-33;

(8) A pharmacist licensed under IC 25-26;

(9) A health facility licensed under IC 16-10-4;

(10) A registered or licensed practical nurse licensed under IC 25-23;

(11) A physical therapist licensed under IC 25-27; or

(12) A home health agency licensed under IC 16-10-2.5.

(b) As used in this chapter, "evaluation of patient care" relates to:

(1) The accuracy of diagnosis;

(2) The propriety, appropriateness, or necessity of care rendered by a professional health care provider; and

(3) The reasonableness of the utilization of services, procedures and facilities in the treatment of individual patients.

As used in this chapter, the term does not relate to charges for services nor to methods used in arriving at diagnoses.

(c) As used in this chapter, "peer review committee" means a committee having the responsibility of evaluation of qualifications of professional health care providers, or of patient care rendered by professional health care providers, or of the merits of a complaint against a professional health care provider that includes a determination or recommendation concerning the complaint. The committee must meet the following criteria:

(1) The committee is organized:

(A) By a state, regional, or local organization of professional health care providers or by a not-for-profit foundation created by such a professional organization for purposes of improvement of patient care;

(B) By the professional staff of a hospital or other health care facility;

(C) By state or federal law or regulation; or

(D) As a governing board of a hospital or professional health care organization.

(2) A majority of the members of the committee are professional health care providers holding licenses in the stated profession of the committee, or the governing board of a hospital or professional health care organization. However, "peer review committee" does not include a medical review panel created under IC 16-9.5-9.1.

(d) As used in this chapter, "professional staff" means all professional health care providers holding licenses in a single profession, authorized to provide health care in a hospital or other health care facility.

(e) As used in this chapter, "personnel of a peer review committee" means not only members of the committee but also all of the committee's employees, representatives, agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serves a peer review committee in any capacity.

(f) As used in this chapter, "in good faith" refers to an act taken without malice after a reasonable effort to obtain the facts of the matter and in the reasonable belief that the action taken is warranted by the facts known. In all actions to which this chapter applies, good faith shall be presumed; and malice shall be required to be proven by the person aggrieved.

(g) As used in this chapter, "professional health care organization" means an organization composed of professional health care providers.

34-4-12.6-2. Confidentiality and privilege.—(a) All proceedings of a peer review committee shall be confidential, and all communications to a peer review committee shall be privileged communications to the peer review committee. Neither

the personnel of a peer review committee nor any participant in a proceeding therein shall reveal any content of communications to, or the records or determination of, a peer review committee outside the peer committee. However, the governing board of a hospital or professional health care organization may disclose the final action taken with regard to a professional health care provider without violating the provisions of this section. Except as otherwise provided in this chapter, no person who was in attendance at any such peer review committee proceeding shall be permitted or required to disclose any information acquired in connection with or in the course of such proceeding, or to disclose any opinion, recommendation, or evaluation of the committee or of any member thereof. Information otherwise discoverable or admissible from original sources is not to be construed as immune from discovery or use in any proceeding merely because it was presented during proceedings before such peer review committee, nor is a member, employee, or agent of such committee or other person appearing before it to be prevented from testifying as to matters within his knowledge and in accordance with the other provisions of this chapter, but the witness cannot be questioned about this testimony or other proceedings before such committee or about opinions formed by him as a result of committee hearings.

(b) Any professional health care provider under investigation shall be permitted at any time to see any records accumulated by a peer review committee pertaining to his personal practice and shall be offered the opportunity to appear before the peer review committee with adequate representation to hear all charges and findings concerning his practice and to offer rebuttal information, which shall be a part of the record before any disclosure of the charges and findings under this chapter. However, a professional health care provider under investigation in a hospital is entitled to only one [1] evidentiary hearing before a peer review committee of the medical staff and

one [1] additional hearing on appeal before the governing board of the hospital. Communications to, and the records and determinations of, a peer review committee may only be disclosed to the peer review committee of a hospital or other health facility, the disciplinary authority of the professional organization of which the professional health care provider under question is a member, or the appropriate state board of registration and licensure which the committee considers necessary for recommended disciplinary action, and shall otherwise be kept confidential for use only within the scope of the committee's work.

(c) Except in cases of required disclosure as authorized in this chapter, no records or determinations of, or communications to, a peer review committee shall be:

(1) Subject to subpoena or discovery; or

(2) Admissible in evidence;

in any judicial or administrative proceeding, including a proceeding under IC 16-9.5-10, without a prior waiver executed by the committee. Except in cases as authorized in this chapter, the evidentiary privileges created by this section shall be invoked by all witnesses and organizations in all judicial and administrative proceedings unless the witness or organization first has a waiver of the privilege executed in writing, on behalf of the peer review committee holding the privilege, by its chairman, vice chairman, or secretary.

(d) The immunities granted by section 3 [34-4-12.6-3] of this chapter shall not extend to any person who violates the confidentiality requirements of this section.

34-4-12.6-3. Immunity.—(a) There shall be no liability on the part of, and no action of any nature shall arise against, the personnel of a peer review committee for any act, statement made in the confines of the committee, or proceeding thereof made in good faith in regard to evaluation of patient care as

that term is defined and limited in section 1(b) [34-4-12.6-1(b)] of this chapter.

(b) Persons or organizations, including peer review committees, who, in good faith, furnish records, information or assistance to a peer review committee, in regard to evaluation of qualifications of professional health care providers, or of patient care as that term is defined and limited in section 1(b) of this chapter, shall be immune from any civil action arising from such acts.

(c) The personnel of a peer review committee shall be immune from any civil action arising from any determination made in good faith in regard to evaluation of patient care as that term is defined and limited in section 1(b) of this chapter.

(d) No restraining order or injunction shall be issued against a peer review committee or any of the personnel thereof to interfere with the proper functions of the committee acting in good faith in regard to evaluation of patient care as that term is defined and limited in section 1(b) of this chapter.

34-4-12.6-4. Use of information obtained by peer review committees.—A professional health care provider, a peer review committee, and the governing board of a hospital or professional health care organization may use information obtained by peer review committees for legitimate internal business purposes, including their own defense.

410 IAC 15-1-1 Definitions

Authority: IC 16-10-1-12; IC 16-10-1-14
Affected: IC 16-10-1-5

Sec. 1. DEFINITIONS. Unless otherwise provided for in the Law [*IC 16-10-1*], the following definitions shall control:

(1) Board—Indiana State Board of Health.

(2) Council—Hospital Licensing Council.

(3) Hospital—A facility that provides continuous and uninterrupted service to inpatients under the supervision of physicians, which is classified as such by the Council and the Board in accordance with the definition contained in IC 1971, 16-10-1-6. Any patient care establishment (excluding mental institutions) caring for patients for more than twenty-four (24) hours which provides on the premises one (1) or more of the specialized services of X-ray, laboratory, pharmacy, or other technical services requiring professionally-trained personnel in attendance shall be considered as functioning as a hospital. Hospital units of any type which operate only a portion of the year may be considered as providing continuous services for the population group served and must have a firm commitment with a local hospital for transfer of patients.

(4) General Hospital—A hospital which provides hospitalization which is not limited to specific diseases, conditions, or age groups. Maternity care may or may not be provided.

(5) Specialized Hospital—Any hospital which provides hospitalization limited to a specified disease(s), condition, or age group.

(6) Hospitalization—The reception and care of any person for the purpose of giving advice, diagnosis, or treatment bearing primarily on the physical health of such persons and maternity care involving labor and delivery for any period of time.

(7) Medical Staff—The organized body of individuals holding appointments by the Governing Body of the hospital to membership on the Medical Staff of the hospital.

(8) Governing Body—The Governing Board, Board of Trustees or the owner or the person(s) designated by the owner as the governing authority.

(9) Physician—Any person holding an unlimited license to practice medicine or osteopathy, including surgery and obstetrics, in Indiana.

(10) Dentist—Any person holding an unlimited license to practice dentistry in Indiana.

410 IAC 15-1-2 Compliance with regulations; exceptions

Authority: IC 16-10-1-12; IC 16-10-1-14
Affected: IC 16-10-1

Sec. 2. COMPLIANCE WITH REGULATIONS. All hospitals shall comply with all regulations set forth herein, except those concerned with clinical services not provided in the hospital. Any situation that may arise which prevents a hospital from complying with any applicable regulation shall be reported to the Council. The Council may, upon written request, permit continuation of operation for a specified period of time, provided compliance with regulations is not immediately attainable and the safety and well-being of patients will not be jeopardized. In event of flood, fire, or other disaster, the Governing Body shall close all or part of the facility as may be necessary to insure the safety and well-being of patients until the Board approves reopening.

410 IAC 15-1-5 Governing body; powers and duties

Authority: IC 16-10-1-12; IC 16-10-1-14
Affected: IC 16-10-1-6.5; IC 16-10-1-9

Sec. 5. THE GOVERNING BODY. The governing board of the hospital shall be the supreme authority in the hospital, responsible for the management, operation, functioning, and control of the hospital. The Governing Body shall:

(a) File an application for licensure with the Board each year. Initial applications must be accompanied by documentation proving that the facility is legally organized and able and willing to meet hospital licensing regulations.

Reapplication must be filed during the year if there is a change in ownership. Written notification within thirty (30) days is to be made to the Board if there is a change in normal bed capacity as required in Item 10.6(e)(1)(b) [*410 IAC 15-1-10(6)(e)(1)(b)*], or change in clinical services other than those for which the license was issued. Current copies of organizational documents shall be available for inspection and forwarded to the Board upon request.

(b) Adopt bylaws and function accordingly.

(c) Have available for its use and for its administrator a written set of current (reviewed within the last two (2) years) goals and policies, long-range plans, and future goals and programs of the hospital.

(d) Employ an administrator with qualifications as set forth in Item 6.1 [*410 IAC 1-6(1)*] as the chief executive officer who is the liaison officer of the governing body to the Medical Staff.

(e) Define the responsibility and authority of the hospital administrator. Total responsibility and authority for management shall rest with the hospital administrator.

(f) Make provisions for an adequate budget for the hospital in order to meet the needs of patients.

(g) Approve the bylaws, rules, and regulations of the Medical Staff and audit procedures of other measures used to assure quality of care.

(h) Appoint members of the Medical Staff and assign privileges consistent with their individual training, experience, and other qualifications on a periodic basis (at least every two (2) years) with the advice and recommendations of the organized Medical Staff.

(i) Maintain liaison with the Medical Staff, preferably by an Advisory Committee with representation from the governing body, Medical Staff, and administration.

(j) Provide for a licensed physician to be on duty or on call at all times for in-house and emergency room call and available within fifteen (15) or twenty (20) minutes.

(k) Provide for close relationship with the community and its various health and welfare agencies.

(l) Provide for the administrator to attend meetings of the governing body and its committees.

(m) Designate the administrator or his designee as the Governing Body's representative for Medical Staff meetings.

(n) Review at least annually reports of operation, including patient services provided and results attained.

(o) Provide a physical plant that meets statutory requirements and provisions of these regulations.

(p) Space and equipment shall be provided for administrative and business offices, private admitting area, public lobby and toilets, personnel toilet and locker facilities, meeting or multipurpose rooms, and medical record facilities.

410 IAC 15-1-7 Medical staff; powers and duties

Authority: IC 16-10-1-12; IC 16-10-1-14
Affected: IC 16-10-1-6.5

Sec. 7. THE MEDICAL STAFF. (1) The Medical Staff of a hospital composed of two (2) or more physicians shall be an organized group which shall be responsible to the governing board for the clinical and scientific work of the hospital, advise regarding professional matters and policies to the governing board, or the board's designee, and shall have the responsibility of reviewing the professional practices in the hospital for the purpose of reducing morbidity and mortality, and for the improvement of the care of patients in the hospital. This review shall include, but shall not be limited to, the quality and

necessity of the care provided patients and the preventability of complications and deaths occurring in the hospital.

(2) The medical staff shall initiate and, with the approval of the Governing Body, adopt and periodically amend bylaws, rules, regulations, and policies which shall include, but need not be limited to, provisions for:

(a) Qualifications to be met for appointment to staff membership and for delineation of privileges.

(b) Assignment of staff members to active, consulting, or other staff group(s) which may be established.

(c) Designation of a chief or chairman of staff and chief of each department or service which may be established.

(d) Establishment of mechanism to carry out Medical Staff functions either by the staff as a whole or by designated committees in the following areas:

(1) Review of applications for staff membership delineation of privileges, and recommendations on appointment to the Governing Body.

(2) Appeal of decisions regarding Medical Staff membership and privileges.

(3) Review and analysis, at regular stated intervals, of clinical performance, pathological reports, the completeness of medical records and of the enforcement of requirements related thereto, of infection control, of use of blood and blood-related elements, and of total patient care.

(4) Participate in the established means of liaison with the Governing Body.

(e) Meetings of the staff as a whole or by department (when staff is well departmentalized) on a monthly basis.

(f) Maintenance of records on all meetings of the staff and committees thereof; however, these minutes shall be considered confidential.

(g) Consultation between physicians in cases when the diagnosis is obscure, or the best therapeutic measures are in doubt is required as part of the bylaws of the Medical Staff.

(3) Current constitution, bylaws, rules, and regulations adopted shall be made available for inspection and forwarded to the Board upon request.

410 IAC 15-1-8 Recordkeeping requirements

Authority: IC 16-10-1-12; IC 16-10-1-14
Affected: IC 16-10-1-13

Sec. 8. DOCUMENTS, REPORTS AND RECORDS. (1) Documents and records which show ownership and compliance with local, state and federal laws and regulations and adherence to bylaws and regulations of the facility shall be maintained within the hospital and shall be made available for examination by duly authorized representatives of the Council and the Board of Health. Items to be maintained are:

(a) Certified copy of Articles of Incorporation (not required of governmental hospitals or individual ownership).

(b) Constitutions, bylaws, and regulations of Governing Body and Medical Staff (signed and dated).

(c) Minutes of meetings of both the Governing Body, Medical Staff, and their committees thereof; such minutes shall be considered confidential.

(d) A current roster of members of Medical Staff and their designated privileges.

(e) A completed application for each member of the Medical Staff which includes the following data: Date of application, professional education and training by school and year, date of licensure, and number thereof in Indiana, Drug Enforcement Administration number, experience in the practice of medicine, type of Medical Staff appointment

and delineation of privileges desired, Medicaid provider number, if one is assigned, pledge to abide by rules and regulations of the hospital, and other items specified by the hospital and its Medical Staff.

(f) The current Indiana licensure or certification number (and serial number if issued) issued by the applicable official agency for physicians, dentists, pharmacists, nurses, physical therapists, and others as required.

(g) Personnel records for each employee of the facility which include personal data, education and experience, evidence of participation in job-related educational activities, and records of employees which relate to pre-employment and subsequent physical examinations, immunizations and chest X-rays and tuberculin tests.

(h) Pharmacy permit when required by Indiana Board of Pharmacy.

(i) Transfer agreements with nursing homes and other hospitals where indicated.

(2) Hospital Records of Patients

(a) Each hospital shall keep a record of all admissions, deaths, surgical records, outpatient records, deliveries, births, and stillbirths which give patient identification data, attending physician, results, and such pertinent data as is deemed needed by the hospital. Computerized records that maintain confidentiality are acceptable.

(3) Reports to State Board of Health

(a) Reports on the hospital and its operation shall be submitted on forms provided as specified by the Council.

(b) Reports of cases of disease shall be submitted as required by state communicable disease and tuberculosis laws and regulations.

844 IAC 4-6-1 Mandatory registration; time

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5

Sec. 1. Mandatory registration: time. Every physician holding a license issued by the Medical Licensing Board of Indiana shall register with the Board on or before July the 1st, biennially, with the exception that no registration or fee for registration is required of any licensee on or before the month of July of the year following the year within which his license was issued.

844 IAC 4-6-2 Mandatory registration; notice

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5

Sec. 2. Mandatory registration: notice. On or before June the 15th, biennially, the Medical Licensing Board of Indiana, or its duly authorized agent, shall notify each licensee that he is required to register with the Board. The Board, or its agent, shall furnish each licensee a form to be completed for registration.

844 IAC 4-6-3 Mandatory registration; oath

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5

Sec. 3. Mandatory registration: oath. Applications for initial registration must be made under oath.

844 IAC 4-6-4 Mandatory registration; fees

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5-7

Sec. 4. Mandatory registration: fees. Each licensee shall submit a fee as determined by the Board for each year or fraction thereof, in the form of a certified check, cashers check or postal money order and payable to the order of the Medical Licensing Board of Indiana.

844 IAC 4-6-5 Mandatory registration; delinquent registration

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5

Sec. 5. Mandatory registration: delinquent registration. In the event any licensee fails to submit his certificate of registration on or before September the 1st of every other year, he shall be required to pay a penalty fee in the amount of $20.00, in addition to the regular registration fee.

844 IAC 4-6-6 Mandatory registration; failure to register

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5

Sec. 6. Mandatory registration: failure to register. Upon the failure of any licensee to register with the Board by September the 1st of each biennium, the Board shall forthwith enter an order suspending the physician's license to practice medicine in the State of Indiana. Such order shall become effective ten (10) days from the entry thereof. A copy, thereof, shall be served upon the licensee by certified mail at the last address registered with the Board.

844 IAC 4-6-7 Practice after suspension

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5

Sec. 7. Practice after suspension. No physician shall engage in the practice of medicine in Indiana after the effective date of the order suspending his license to practice.

844 IAC 4-6-8 Reinstatement of physician to practice

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5

Sec. 8. Reinstatement of physician to practice. Every physician who has become delinquent in registration may be reinstated to practice by supplying the information requested by

the Board and paying a delinquent registration fee for the time accrued. The delinquent penalty fee shall be the sum of $20.00, in addition to the regular registration fee.

844 IAC 4-6-9 Inactive status

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5

Sec. 9. Inactive status. Any physician who has retired from practice and wants to retain his license may do so for half of the usual registration fee as given in Rule 2 844 IAC 4-2-1, provided that he does not maintain an office for the practice of medicine and does not charge for any medical services that he might render. A physician whose license is inactive may submit a written request to the Board to reactivate his license by paying the full registration fee.

844 IAC 4-6-10 Probation, suspension, or revocation

Authority: IC 25-22.5-2-7
Affected: IC 25-22.5

Sec. 10. Probation, suspension, or revocation. The willful performance of an act likely to deceive or harm the public shall include, but not be limited to the following acts:

(1) Aiding and abetting a person to practice medicine without a license;

(2) Presigning of prescriptions;

(3) Prescribing or administering a drug for other than generally accepted therapeutic purposes;

(4) Gross negligence in the practice of medicine;

(5) False, deceptive, or misleading advertising;

(6) Fraudulent practice of billing a patient or third party payer for services not rendered.

No. 84-1406

Office-Supreme Court, U.S.
FILED
JUN 5 1985
ALEXANDER L. STEVAS,
CLERK

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OCTOBER TERM, 1984

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Petitioners,

v.

INTERQUAL, INC., et al.,

Respondents.

REPLY TO THE BRIEF OF RESPONDENTS IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI

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SUMMARY OF ARGUMENT

The respondents' brief has highlighted the reasons why this Court should review the decision of the Seventh Circuit Court of Appeals. "Indirect" administrative review, consisting of a hospital governing board's report of an adverse recommendation by a peer review committee to the Medical Licensing Board of the State of Indiana, and a Hospital Licensing

Council's possible review of hospital records represents a radical departure from this Court's pronouncement of the doctrine of "active state supervision." This type of "indirect" administrative review provides no opportunity for Indiana to implement its policy of providing quality medical care to its citizens since there exists no mechanism within the state administrative process to review, reverse or affirm, peer review decisions.

Courts, on the other hand, are constitutionally incapable of implementing or supervising state policies but rather are limited to adjudicating the case or controversy placed before it by the parties. A court may not, as suggested by the Seventh Circuit, provide active state supervision of the peer review process. Furthermore, Indiana's grant of immunity from civil lawsuits for those involved in peer review extends only to peer review activities conducted in "good faith." In addition, Indiana did not attempt to limit to state courts any civil action brought because the proceedings were conducted in "bad" faith. Since federal courts have an unflagging obligation to exercise the jurisdiction given them, the Seventh Circuit errored by rejecting its congressionally imposed jurisdictional mandate.

The state court action brought by Dr. Marrese was one for preliminary injunction brought after the dismissal of this action but before the commencement of the peer review proceeding. A state court finding that he had failed to show the panel members' "malice" at that time does not in any way address the issue of whether or not those peer review proceedings were conducted in "good faith." Nevertheless no court, state or federal, has considered the facts or issues raised in this litigation.

In light of the Indiana Legislature's grant of immunity from civil action only to the extent that the peer review activities are conducted in "good faith" there exists *no* conflict between the state policy of providing high quality medical care for its citizens and the federal antitrust laws.

ARGUMENT

The respondents' brief in opposition ("Opposition") to the petition ("Petition") clearly demonstrates that the alleged anticompetitive actions of respondents were those of private parties masquerading their anticompetitive activities as "state action." Indeed, the State of Indiana has clearly stated its position in the *Amicus* brief that the perversion of the peer review process for anticompetitive purposes is not consistent with state policy. This decision, if not reviewed, will spawn a new generation of confusion in the area of the "state action immunity" doctrine. The reasons for this are addressed in this reply.

I. "INDIRECT" ADMINISTRATIVE REVIEW IS NOT "ACTIVE STATE SUPERVISION" NOR CAN SUCH SUPERVISION EVER BE THE PROVINCE OF THE COURTS

A) "INDIRECT" ADMINISTRATIVE REVIEW CONSISTING OF A REPORT OF AN ADVERSE RECOMMENDATION TO A MEDICAL LICENSING BOARD OR A HOSPITAL LICENSING COUNCIL'S POSSIBLE READING OF A PEER REVIEW RECORD, WHEN NEITHER AGENCY HAS THE RIGHT TO AFFECT A PEER REVIEW DECISION, CANNOT BE "ACTIVE STATE SUPERVISION" OF SUCH A DECISION WITHIN THE MEANING OF *PARKER v. BROWN.*

The respondents have attempted to defend the Seventh Circuit's unprecedented decision on the basis that "active state supervision" can be equated to "indirect administrative review" because a hospital governing board reports any adverse findings of a peer review committee to the Medical Licensing Board and because the Hospital Licensing Council has the right to make periodic inspections of a hospital and inspect hospital

documents. Because neither the Medical Licensing Board nor the Hospital Licensing Council has the right to affect in the slightest way a hospital's peer review decision, the Seventh Circuit's theory is unsupported by case law and contrary to the interpretation given this procedure by the highest law enforcement officer in the State of Indiana, its Attorney General.

In *Hoover v. Ronwin*, ____ U.S. ____, 104 S.Ct. 1989, 80 L.Ed. 2d 590 (1984), this Court found "active state supervision" because the Arizona Supreme Court had reserved to itself the crucial decision of whether to admit or not to admit an applicant to the Arizona Bar, the very procedure challenged by Mr. Ronwin.

Similarly, in *Parker v. Brown*, 317 U.S. 341, 353 (1943), the State Commissioner of Agriculture was charged with determining the supply and price of all raisins sold under the legislatively approved marketing program.

Conversely, in *California Retail Liquor Dealers Ass'n. v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105-106 (1980), the state's failure to establish prices, review the reasonableness of price schedules, regulate the terms of fair trade contracts, monitor market conditions and re-examine the program all were found to show a lack of active state supervision of that price setting policy.

In the instant case the respondents' decision to remove Dr. Marrese's from the Hospital staff was exclusively their own: that decision became effective when made and neither the state nor any of its agencies were involved in that decision-making process in any way nor did they review or regulate the circumstances or the reasonableness of that decision. Neither the Medical Licensing Board nor the Hospital Licensing Council were authorized to name the hearing panel nor name a representative to that panel.

The operative decision, to remove Dr. Marrese from the Hospital staff, was made by private parties and not by a

governmental body and neither the Medical Licensing Board nor Hospital Licensing Council had a mechanism to review that decision. In these circumstances the respondents' novel doctrine of "indirect administrative review" must be regarded as merely a clever confusion of the supervision issue. Whatever that terms means, it cannot conceal the absence of the necessary *active state supervision* in this case.

B) A COURT IS CONSTITUTIONALLY INCAPABLE OF PROVIDING "ACTIVE SUPERVISION" OF THE PEER REVIEW PROCESS

Based upon the Seventh Circuit's opinion in the instant case (App. 39-43) respondents argue that "active state supervision" may be found when there exists a possibility of state judicial review (Opp. 24). This represents the ultimate in total perversion of the principals of *Parker v. Brown.* The Seventh Circuit's expansive interpretation of "active state supervision" will give birth once again to "a crazy quilt of desperate rationales and rubrics," Handler, *Antitrust-1978,* 78 Columbia Law Review 1363, 1374 (1978), since a court is constitutionally incapable of either implementing or supervising a state policy favoring quality medical care. It is limited to adjudicating the case or controversy placed before it by the parties.

Although the Seventh Circuit felt that the state policy favoring peer review would be better enforced in the state court, the Indiana Legislature was silent on this issue and extended state court immunity only if those proceedings were conducted in good faith. The lack of such a legislative expression of preference should have alerted the Seventh Circuit to the dangers of entering on such an unchartered course. In so doing the court has lost track of the fact that federal courts have an unflagging obligation to exercise the jurisdiction given them. As Justice Brennan pointed out in *England v. Louisiana State Board of Medical Examiners,* 375 U.S. 411, 415 (1964), to require a litigant who has properly

invoked the jurisdiction of a federal court to consider a federal claim to accept a state court's determination of his claim instead "would be at war with the unqualified terms in which Congress, pursuant to constitutional authorization, has conferred specific categories of jurisdiction upon the federal courts . . . ." The Seventh Circuit has failed to exercise its Sherman Act jurisdiction and for this reason alone petitioners' request for a Writ of Certiorari to that court should be granted.

II. THE STATE COURT ACTION, BROUGHT PRIOR TO THE PEER REVIEW HEARING BUT, AFTER THE FEDERAL COURTS' DISMISSAL OF THIS ACTION, HAS NO BEARING ON THE ISSUE OF "STATE ACTION" EXEMPTION

In order to avoid confusion, it must be pointed out that the state court action brought by Dr. Marrese was simply an action for preliminary injunction wherein Dr. Marrese sought to establish the "malice" of the hearing panel *prior* to the commencement of the peer review hearing.[1] The state court's

[1] In this context, it is important to note that the president of the medical staff, who initially named the hearing panel in 1982, is a defendant in this litigation. His partner was president of the medical staff in May, 1983 and he named the same panel as was named by his partner-predecessor and the alternate panel. The panel consisting of hospital staff members was composed of a physician who was a father of a witness scheduled to testify against Dr. Marrese, two physicians who were partners of witnesses scheduled to testify, one member who was noted for his strong personal bias against orthopedic surgeons performing spinal disc surgery and one who had no knowledge of spinal procedures. The past and then current president of the medical staff designated this panel notwithstanding the fact that there were at least 160 physicians on the staff of the Hospital who were not so tainted and there were approximately 200 orthopedic surgeons in the State of Indiana who were not asked to serve on the hearing panel.

The alternate panel "associated with Indiana University Medical School" consisted of only *three* rather than *five* physicians as called for in the Hospital by-laws and this panel also was hand-picked by the

(Footnote continued on following page)

finding that the composition of the amended peer review panel did not of itself prove "malice" within the meaning of the state statute is simply irrelevant for federal antitrust purposes and for the purpose of determining whether the proceedings were conducted in good faith. It has no bearing whatsoever on the issue of whether the alleged anticompetitive intent to exclude Dr. Marrese from the relevant market, to coerce conformity to anticompetitive trade practices throughout the market and to monopolize that market caused the peer review proceeding to be commenced against Dr. Marrese. Thus, assuming the truth of the allegations that the primary purposes of the peer review proceedings were to exclude a feared competitor from the market and to coerce conformity to the alleged "apprenticeship" and "prior referral" trade practices, the limited state court

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(Footnote continued from preceding page)

president of the medical staff who was a partner of a defendant in this litigation. None of the three prospective "alternate" panel members had specialized knowledge concerning adult orthopedic spinal surgery. There were in fact other very persuasive reasons for Dr. Marrese's not accepting this alternate panel which will be put in admissible, evidentiary form at the appropriate time.

The statement of respondents that a panel member was "voluntarily withdrawn" is, at best, misleading. Two panel members who were partners of defendants in this litigation and named by a defendant in this litigation and renamed by his business partner, voluntarily withdrew as panel members, one ten days before the hearing and the other during the preliminary injunction hearing in the state court. When the first panel member voluntarily withdrew the president of the medical staff named another partner of a defendant in this litigation to the panel. When the second panel member withdrew during the hearing on the preliminary injunction the president of the medical staff advised the circuit judge that he was naming another staff member as panel member but did not advise the judge that the panel member he was naming was a defendant in this litigation. That defendant withdrew from the panel on the morning that the peer review hearing was to commence when the Circuit Judge, off the record, withdrew his approval of that panel member. The hearing proceeded with a panel of four rather than five members, as called for in the by-laws.

finding could not prevent the imposition or alter the rule of per se federal antitrust liability.

As courts have consistently held, the "good faith" or "reasonableness" of any practice that comes within one of the per se categories is no defense to liability. *United States v. Trans-Missouri Freight Assn.*, 166 U.S. 290, 342 (1897); *Marjorie Webster Jr. College v. Middlestates Assn. of Colleges*, 302 F.Supp. 459, 466 (D.C.Cir. 1969) *rev'd on other grounds*, 432 F.2d 650 (D.C.Cir. 1970), *cert. denied*, 400 U.S. 965 (1970). Here, of course, there has been no finding of "good faith" in the institution, prosecution or outcome of the Deaconess Hospital's peer review proceedings and no court, state or federal has reviewed the facts or issues raised in this litigation.

III. PETITIONERS ARE NOT CHALLENGING THE CONCEPT OF MERIT-BASED PEER REVIEW BUT RATHER THE ABUSE OF THE PEER REVIEW PROCESS BY RESPONDENTS FOR THE PURPOSE OF REMOVING A HIGHLY QUALIFIED COMPETITOR FROM THE HOSPITAL STAFF

Respondents argue that since peer review is authorized by the Indiana Legislature (Opp. 20) and since the Indiana Legislature anticipated that "some physicians would be involuntarily removed from hospital staffs" (Opp. 18-19), all anticompetitive conduct resulting from peer review activities should go unchecked. This argument ignores the fact that federal regard for state policy does not require antitrust immunity if application of the antitrust laws would not be inconsistent with state policy. By authorizing "good faith" peer review in order to assure quality medical care, the Indiana Legislature was sanctioning merit-based exclusion of physicians from hospital medical staffs. Petitioners are not challenging the peer review process itself, but rather the perversion of that process by respondents (Pet. 10-11). Since the Indiana policy favoring peer review is founded upon concern for the delivery of quality medical services, it is in that context that the Indiana Legisla-

ture can reasonably be said to have "anticipated that some physicians would be involuntarily removed from hospital staffs" (Opp. 18-19). Clearly though, a non-merit-based removal of a competitor from a medical staff who is an economic threat to the persons recommending that removal was not sanctioned by the Indiana Legislature. Therefore, the state's statute authorizing peer review is consistent with the federal antitrust law and there is no issue of state preemption as argued in respondents' brief (Opp. 28). See *United States v. Erie County Malt Beverage Dist. Ass.*, 264 F.2d 731 (3rd Cir. 1959).

This "state purpose" analysis is entirely consistent with this Court's recent decision in *Town of Hallie v. City of Eau Claire*, ____ U.S. ____, 82-1832 (1985), 53 L.W. 4418, where the Wisconsin statutes "clearly articulated" a state policy authorizing a city to construct and maintain sewage systems, to describe districts to be served and to refuse to serve an unannexed area. The state was said not to be merely neutral on the challenged issue, but clearly contemplated that a city may engage in anticompetitive conduct. Similarly in *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 789 (1975), the court refused to immunize a bar association minimum fee schedule on the grounds that the Virginia Supreme Court's general grant of authority to the bar to issue ethical opinions was not intended to authorize binding price fixing.

CONCLUSION

The State of Indiana, not unlike every other state in this nation, has an extensive statutory and regulatory scheme concerning medical services. Hospitals are the focal point of modern health care, providng the equipment and support personnel necessary for today's sophisticated medical procedures. Access is therefore indispensable to medical practitioners. These facts are recognized by consumers of medical services who increasingly are seeking more advanced medical procedures and a greater variety of treatment modes. Staff members, cognizant of this fact, and of their advantage as a result of their staff membership, will be encouraged, by this decision, to recommend the denial of staff privileges or the removal of a staff member for reasons totally unrelated to merit. The consumer will therefore suffer because a hospital medical staff will be able to control the type of medical services delivered by a hospital to a community, not because the services are inferior but rather because other staff members are incapable of forming these procedures. This Court should avail itself of the opportunity presented to develop guidelines for the protection of consumers of medical services and those entering or presently in the medical profession. Petitioners therefore requests that this court issue a Writ of Certiorari to the Seventh Circuit Court of Appeals.

Respectfully submitted,

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